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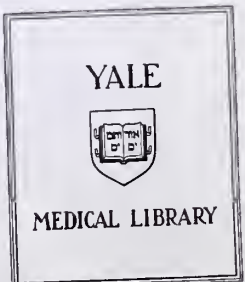
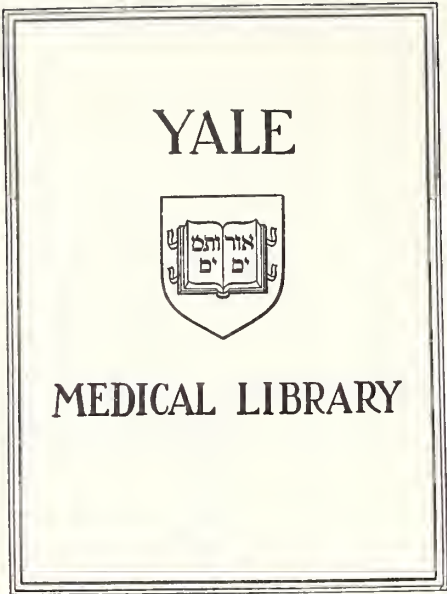
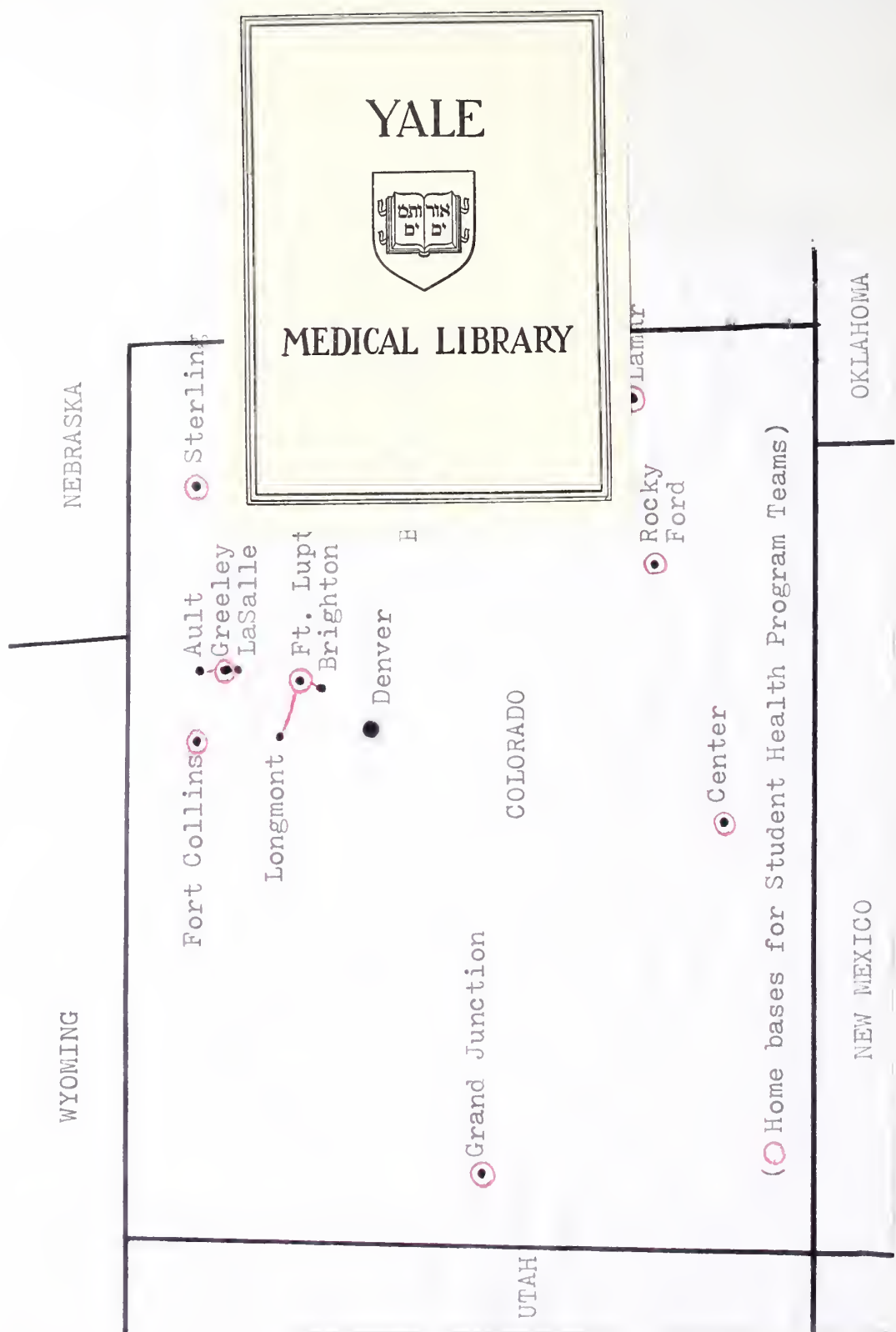


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THE HEALTH CARE OF MIGRANT FARMWORKER FAMILIES

ELIZABETH MICHEL

1975



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THE HEALTH CARE OF MIGRANT FARMWORKER FAMILIES

A Dissertation
Presented to
the Faculty of the Medical School
Yale University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Medicine

by
Elizabeth Michel

March 1975

PREFACE

Last summer I worked in Colorado in the Student Health Program for Migrant Farmworkers and Rural Poor. My thesis is an attempt to make sense out of that experience.

My coworkers and I tried to deliver a certain kind of health care. To make sense out of this part of the experience, I researched the outcome of our project systematically enough to make some intellectual judgements about it.

To make sense out of the overwhelming health needs of migrant farmworkers, I learned more about their economic, social, and political needs. I had to think, too, about the health care of all Americans. I could not look at national health policy for migrant farmworkers without considering the changes that would benefit us all.

Hardest of all was making sense out of the person inside my health-care role. Health care is always delivered within the context of personal interactions, and this was especially true in my work last summer. The pleasures and aggravations of participating in an interdisciplinary health team were integral to my experience, and I cannot leave them out. My patients were people of great warmth, and I cannot separate my own feelings of warmth for them from the health care I tried to give them. To omit that would be dishonest. To ignore that would leave me feeling empty.

I am very grateful to David Duncombe, my advisor, for his time and support. His editing was extremely helpful but, most important, he encouraged me to write about the parts of health care, and myself, that matter most to me.

I am thankful for the friendships of last summer. "Gracias" especially to Donna for hers.

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Chapter 1

THE CLINIC

New summer.

We pulled off the main street and cautiously crossed the mound of the railroad tracks. Then a left turn, and there was the clinic, in the middle of the block. It presented a clean glass face to the street, but it had been allotted no more space than any of the little white houses on this side of town.

I was smug: a real store-front clinic, and literally on the other side of the tracks. During three years of mostly medical study, I had bracketed off (at times with relief, usually with guilt) three earlier years of student activism. Three years of lean, three years of fat. I was reintegrating.

According to a Pepsi-Cola sign in the window, the clinic was closed. I knocked anyway, again and again. Finally a blond woman bobbed into and out of sight and, that quickly, made up her mind about me. She ignored me.

We explored the side yard and found the back door open. Within the black of a cool room entered from a glaring day, the blond woman and another, dark woman were eating sandwiches.

I introduced myself and Arnie. "I'm the medical

student who is going to work here this summer."

"Oh." The blond woman made all the replies. "I thought you were a patient. If you let them in, you never get to have your lunch hour."

I thought: What's an unfriendly, tall blond lady like you doing in a community clinic for short dark people?

She told us where we could go for lunch.

Later I understood that, to the clinic higher-ups, I was not to be one of "us" but one of "them" from the Student Health Program.

When we returned, Karen was waiting for me. She had been in the Student Health Program the previous summer and would be an area coordinator this year, as well as a member of the Greeley team. Her welcome was a warm relief. She had rented a room for herself and Eileen, a nursing student who would be arriving the next week. Karen immediately invited me to stay with her for a few days and offered to help me to find a room.

Arnie and I followed her in our car for several blocks, beyond the tracks and the main street. Here the houses were larger and of varied colors, and trees lined the streets like many prisms breaking a hard sunstream into soft bands of dappled light. Karen left us at her room to separate out the clothing in our big suitcase and to say goodbye. We were used to doing almost everything together: we ate breakfast together, went to school together, took the same classes or worked on adjacent wards, came home together,

cooked and ate supper together, studied together, visited friends or saw a movie together, went to bed together. In April we had received assignments to "adjacent towns," Greeley and Sterling. We had gotten out our atlas and seen that they were adjacent in a sense--there was no other real town along the hundred-mile road between them.

The tall blond turned out to be the head nurse. That afternoon she took me through the clinic and explained procedures as we went along. Both the front and back waiting rooms had filled with patients, mostly women and children. In front, by a coffee percolator, patients waited on wooden benches, beneath signs printed in Spanish and English, to register with the receptionist, then to explain their problems to a nurse in one of the little rooms off the corridor. After that they waited in back, by the soft-drink machine, for the lab work ordered by the nurse, and then to see the doctor in another little room.

When Dr. Barra arrived, she gave me a copy of the clinic's grant proposal to read over and began to call patients into her examining room. She was very young and, like all the staff, dressed in street clothes and no white coat. Karen had already told me that Dr. Barra had been a student in our program about five years ago and had since dedicated herself to providing health services to the migrant farmworkers and poor people in the Greeley area.

The Student Health Program had not sent us any

information about our specific work assignments. As we had driven up from Denver that morning, I had felt as if I were floating into an empty expanse, floored by the early green of the endless flat fields and roofed by the endless blue sky, but endless. No hills shaped the land into limiting spaces. I was uneasy: I was on the land but not in it, not of it. And the land was so empty of people. Although I sat now in a tiny room in a cramped clinic, in my thoughts that clinic was also floating on the land, without relation to the land.

The grant proposal populated the land for me and set structures onto it. The land was Weld County and the people were 89,000 in number. Many of them were poor: 19% of the families had an income of less than \$3,000 a year. During the growing season, approximately 7,500 migrant farmworkers entered Weld County. The clinic settled into place for me. It was surrounded, besieged by people in need of care. The proposal estimated that approximately 16,000 people in Weld County were medically indigent: 7,500 migrants plus 8,500 seasonal farmworkers and rural poor residing permanently in the county. At its proposed funding level the clinic would be able to serve only 30% of these people in the 1974-1975 year.

In order to make the clinic responsive to the needs of Mexican-Americans, the grant proposal required that a majority of the staff be bilingual and bicultural. Several of the staff members were also to be from the "target

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population" of migrant and seasonal farmworkers. As Project Director as well as Staff Physician, Dr. Barra coordinated health services and supervised the staff. A Consumer Policy Board, the grant admitted, had previously been hindered by fighting among the members. Now it was functioning well and reviewing all clinic policies. Nine members were to be elected by the consumer population, and eight were to be community-at-large representatives appointed by the Board. The Chairman of the Board was Dr. Barra.

The proposal emphasized that, when the Mexican-American farmworker could find health care facilities at all, he was not likely to obtain "quality health care which is provided in an atmosphere which is aware of and respects his culture." That scared me. Right there in that clinic, at that moment, were more Mexican-Americans than I had ever met in my life. In the spring I had thought that I had learned something about Mexican-American culture from two books I had read. Now they were only dead words that could not smooth my stumbling through live interactions. My stomach lurched through my gut as my doom struck me: I would commit dreadful sins of disrespect. No one would like me. I hated myself already.

Then I recognized fear's old antics and tried to turn down the voltage in my autonomic system. I reasoned with myself. I had been afraid of cultural differences, and of hostility, when I had started working the year before in outpatient clinics at Yale with poor patients, black,

white, and Puerto Rican. In the end I had had warm relationships with several patients. It was there, in fact, that I had realized that I liked my patients--that my greatest pleasure in medical school had always been getting to know them and their life situations--for my first relationships with patients had been on hospital wards, where the house staff joked and jeered interminably about patients. Now I reasoned myself into believing that I would like my Mexican-American patients as well, and that my liking for them as individuals would make cultural differences surmountable.

It was my first experience, really, in working on my own. During the past year I had been the primary doctor for several patients but, when I was assigned a new patient in Outpatient Clinic, I had two hours to talk to my patient, examine him or her, and discuss my patient's problems with one of four attending physicians (who saw no patients of their own but came only to teach and supervise us). Now I had time to deal only with a patient's main problem, to do only part of a physical examination, and to check only briefly with Dr. Barra, also busy with her own patients, about each patient's treatment.

I was glad to trade in the ease of time I had had at Yale for the political and moral congruity I found at the clinic. I knew that I was kind to my patients at Yale, that I tried to discover their real needs, physical and emotional, and help them. But I remained a traitor to them. Most of

them were on Welfare and were used to coming to the hospital for health care. Their social needs were tremendous, and I was a traitor for working in a powerful institution that used them to its own purposes--my learning included--and ignored, even opposed at times, their real needs. It was clear-cut exploitation, and I was ashamed. I was a traitor to my patients for caring about them, for making them think they could trust me--and then, like every medical student, just rotating through and leaving them. If they remained patients at Outpatient Clinic, they would see many, many "doctors," all temporary, all playing at being doctors, and I sometimes encouraged my patients to find their health care elsewhere if they could.

My patients at the clinic were also exploited, and tragically so, but I no longer felt that I was personally deceiving them. There was no need to feel that my patients could get better health care elsewhere because most of them could not get any health care elsewhere. I felt bitter that it should take such a situation to remove my shame about practicing on people to learn my profession, but I did feel more confident of the worth of my work. Consequently I was able to be more honest with my patients, and warmer to them.

I was delighted to find that the full warmth I had failed to show my patients at Yale was an essential part of every treatment plan at the clinic. I had read and heard that Mexican-Americans are usually guarded with strangers.

In fact my patients often seemed uninterested in their health at first encounter, but I was amazed to see how quickly they discarded their initial blandness in response to a sincere and empathic offer of help. Although I spoke Spanish very poorly, I was soon trying to say whatever I could in Spanish to my Spanish-speaking patients. Patients who initially said that they spoke no English often responded by saying as much as they could in English. I still got the details of the patient's illness, and gave the details of treatment, through an interpreter, but the patient and I had made contact through our own efforts.

It was at the clinic that I began to understand the feeling I have about patients in general. I wonder if I had hesitated to analyze it out of fear of bursting its fullness with some ugly psychodynamic motive. Of course I have different reactions to each patient I see, but I carry within me an intense, generalized caring about my patients that feels wonderful to me. There is something ravenous about this emotion, and something omnivorous, as if were not completely different from the primitive hungers of infancy and the pinnings of adolescence. And yet it is not the same: it can be satisfied. It fills me, it feels wonderful within me--but there is no magic in it, only logic. Raised as I was on a diet of affectionate warmth alternated unforeseeably with icy withdrawal that I would once have done anything to forestall, my need is for warmth. If now I care for people, it is because I am realistic. My work suits me. It was

a little risky at first: What if I were friendly and a patient wounded me with wanton anger? Now I have seen enough patients to know that I have gotten what I wanted. I dared gradually to be warmer, to let each patient feel from the start what I wanted in a relationship. It's a kind of honesty, really. Of course there are hostile people, paranoid people, devious people, and at times, as patients, they hurt me. Mostly I have warm patients. When I care well for them and deserve their warmth, I feel indescribably joyous. At times being warm has meant not withdrawing from acknowledging the existence of terrible sadnesses--of chronic illness or death, of loneliness or poverty--and the limits of mortal power. When I have really empathized with a patient whose anguish will die only with time or with death itself, I have felt their anguish. This frightens me: I must feel again the pain of my helplessness to bring back my own losses. When I fail, I am very hard on myself for my weakness. I try not to fail because I have seen my patients brighten a little when I have shared their anguish--as if, through shades of the reality and universality of pain, blame eases into fate. The sad glow of their brightening is my reward; that is warmth, too.

At the clinic I also became comfortable with seeing my patients as families. During my first week there I saw a young woman who was pregnant and had fainted while riding a tractor that afternoon. As I spoke to her, I became increasingly uneasy about the presence of her husband and

A little time, at about 10:30, I was sitting at a

table in the room where the other people were sitting. I was

looking at the people who were sitting at the table.

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At about 10:00, I was sitting at the table.

another, older woman in the room. At Yale I had almost always seen patients alone, and there I had absorbed the idea--or perhaps had actually heard it expressed--that a family that confronted a physician together to discuss one member's problems was overly aggressive or overly defensive and a threat to the physician's efficacy. But physician-patient relationships at Yale are often seen as constant battlegrounds, on which the physician's thrusts at making the patient well again are eternally fended off by the patient, who starts drinking again or stops taking his medication. After each joust the physician returns to the doctor's office to joke about the patient's shortcomings and thus show that he is victorious at least in being innately superior to the patient. What else can this be, this insistence that he knows what the patient ought to do, despite obvious lack of success in getting the patient to agree, other than a snobbery, really, a clinging to status which is at the heart of the failure of our health care system? It happened that this young woman's relatives were quiet people but, out of habit, and out of lack of confidence (which is probably where many of my Yale-bred habits first took life), I interpreted their quiet presence as hostility. Later that evening I went over in my mind what I had felt and what had actually happened, and I realized that the defensiveness had been mine. Soon I was enjoying the lively interactions, and added facts, insights, and humor which relatives would offer when I focused on one patient's

problems.

The proceedings of my first clinic staff meeting startled me. I had obviously made the mistake of equating a community clinic with group decisions. Dr. Barra announced that the Consumer Policy Board had voted to keep the clinic open four evenings a week for the summer, instead of the usual two. Then she read off the working hours which she had assigned to each staff member. I was to work three nights a week. A few of the permanent staff members were to work four nights a week. That afternoon, the clinic mood was sullen. Jackie, the lab technician, a divorcee with four children, talked privately, and for a very long time, with Dr. Barra. We had heard her muttering angrily in the lab that she couldn't possibly be away from home four nights a week, but apparently she was unable to exact a compromise from Dr. Barra.

When I left Greeley two months later, my respect for Dr. Barra's dedication had not decreased. She had worked hard to establish a good clinic and obtain its funding. She was still working hard to give health care to farmworkers as a group and, when she saw them individually, as patients, she was pleasant and concerned. But her inability to share responsibility was bitterly resented by some of the other clinic workers. Jackie resigned early in the summer. Olivia, the clinic receptionist, a lively interpreter and mother-figure who often helped me to reassure young women

while I examined them, left several weeks later. As for our Student Health Program team, Dr. Barra merely tolerated us.

Her welcome to us at our first staff meeting was in substance a warning. We were to follow the orders which she and the two head nurses issued. If we did not, we would be asked to leave. We were not to think that our way of doing something might be better; the clinic had been doing it longer and was therefore right. Since she did not let us know her personally at all, I cannot guess how she came to perceive her position as constantly threatened from all sides. Unfortunately--and in two months' time I was to learn this lesson several times over--it is just such personality problems that often trample the potential of a health service.

Dr. Lewis, the director of the Student Health Program, was another model of dedication. His greatest concern was the success and continued funding of his program, and he never hesitated to subordinate his workers' concerns to his own. He was responsible for placing Arnie and me one hundred miles apart without ever inquiring whether we minded, even though we had indicated on our applications that we were married. It seems that we had originally been assigned to the same town, but several medical students dropped out of the program in the spring. Only three fourth-year students remained for the entire state. Dr. Lewis probably believed that if he were honest with us at that point and asked if we would work so far apart, he would

lose us as well. This a-little-less-than-honest approach, and his way of scolding us all at conferences as if we were toddlers (likely by nature to commit some naughty misdemeanor unless disciplined before the fact) earned him no respect for his interpersonal skills. I respected him, as I respected Dr. Barra, for his dedication to farmworker welfare--and I have wondered ever since if only power-hungry people can successfully run health care programs in this country. The Colorado farmworkers receive much more health care with Dr. Barra's and Dr. Lewis' programs than without them, but with the same funding, the same effort, they could have even more. Not surprisingly, Dr. Barra and Dr. Lewis hated each other, as we all often hate in others what we cannot admit in ourselves. In the end, of course, it was the farmworkers who suffered from lack of cooperation and, at times, actual antagonism between the clinic and our program, and between the power-seeking leaders of several other agencies concerned with migrant health.

As I became frustrated with the overlapping of factions in some migrant health services and the total lack of attention in others, I came to know, through Arnie, a different sort of dedication. Dr. Thornton, his seventy-one-year-old preceptor, had little interest in networks of control, but he did ground his self-esteem in being a "great man" of his town. He was humble, and he was generous of his time and money. For years he had seen migrants, whether or not they could pay, when other physicians would not have

them in their offices even if they could pay. He was on call twenty-four hours a day. He was wonderful.

To us, he was also pathetic. Now, like the old doctor in Ingmar Bergman's film "Wild Strawberries," he was paying with his own loneliness for the admiration of his community. Dr. Thornton told Arnie that his wife and children had left him because he gave all his time to his patients, and so little to them.

I don't worry about finding myself on the escalators of power; I'm not aggressive enough to be good at that. I do worry about time: when intimacy intoxicates me, I thirst for time. Arnie and I saw Dr. Thornton's struggles and enchantments as we had already felt them and, as we knew, we would always feel them. To take time from patients to give to each other, to take time from each other to give to patients--no matter how we scheduled time, there would never be enough of it. Here was an old man who would die soon. He had never had enough time, and now it was running out. Like many of my friends in medical school, I have watched "Wild Strawberries" over and over again. We try to find in its poignancy and sunlight some answer for ourselves, an answer we have not found in ourselves.

As my preceptor, Dr. Barra checked my decision on each patient or told me what to prescribe when I did not know. But she avoided the theoretical discussions which teach students how to think about problems. She taught me

her way of handling various illnesses, and little else. When I returned to Yale in the autumn, it was with new gratitude for clinical teaching which explored alternatives and brought basic sciences to life. Dr. Barra was not open to having her knowledge or methods questioned, and she therefore could not be open to learning from me. Dr. Thornton was quite the opposite: he was always eager to have students in his office because they helped him to keep up with new treatments and attitudes. He still thanks Arnie in his letters for all that Arnie taught him, especially about family planning. The family planning counselor at the Public Health Department usually sent young women to Dr. Thornton's office for their gynecological examinations. In early June, a few who happened to see Arnie there raved about him to the counselor, and thereafter she sent all her clients to him.

One Friday in July, Dr. Thornton asked Arnie, "What do you do in there so long with these girls?"

Arnie outlined for him his explanation of female anatomy, the pelvic examination, and basic sexual response. He told Dr. Thornton about the misconceptions he had already cleared up for many young women in Sterling by offering them information and encouraging their questions.

When Arnie returned to Sterling on Monday, Dr. Thornton told him, "You know, I tried your way of doing family planning this weekend."

"What did you think of it?" Arnie asked.

"Well, it takes a lot longer," Dr. Thornton replied, "but the girls sure seemed to like it better."

Fortunately a Child Health Associate interne began to work at the clinic just when I did, and I often saw cases with her. Although she was not particularly interested in, or sensitive to, the special problems of farmworker families, her theoretical knowledge of pediatrics and her practical skills were excellent. She enjoyed teaching and learning, and because of her I was soon much better equipped to solve the health problems of the migrant children I saw in the schools each day.

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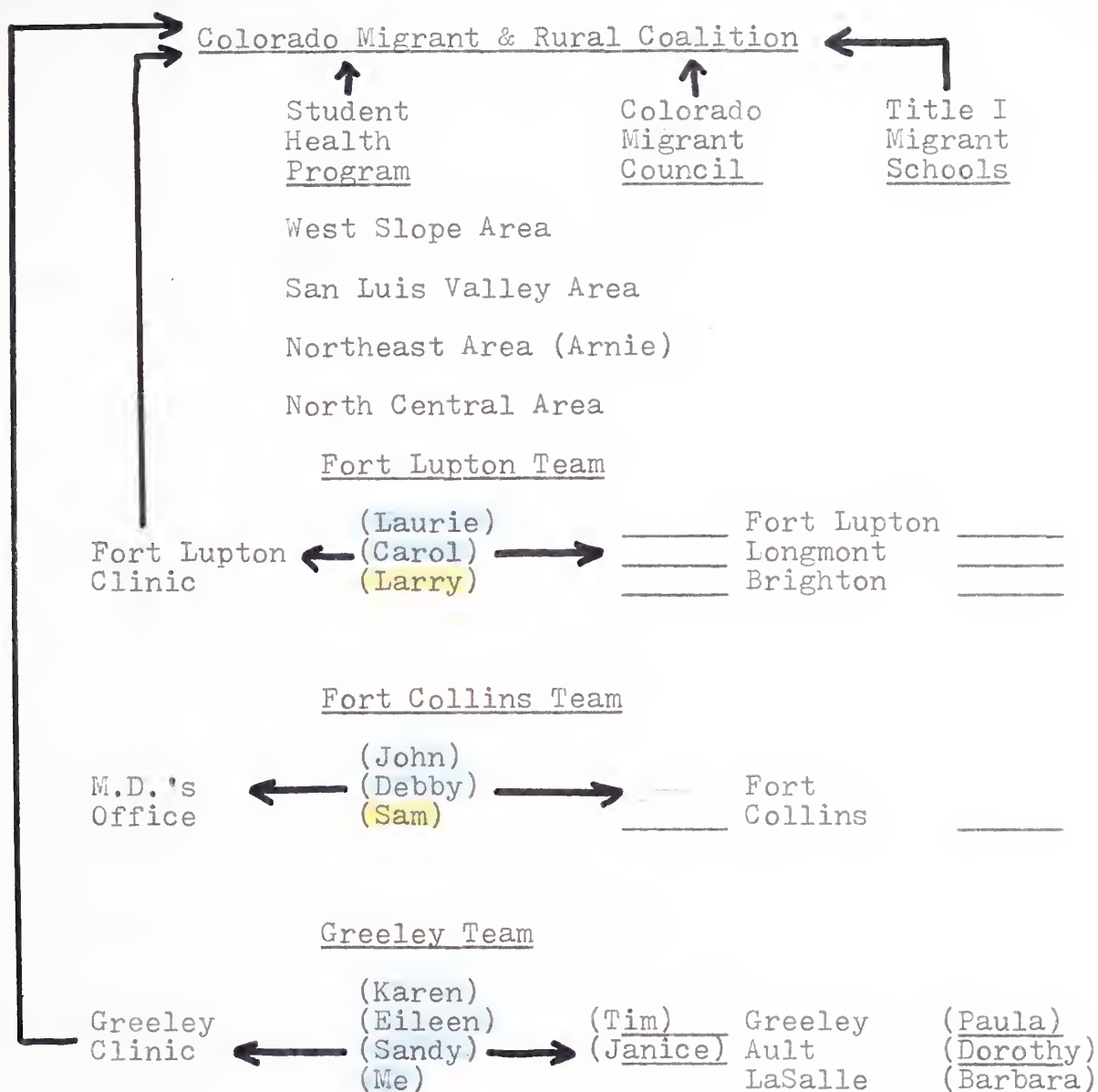
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Chapter 2

THE SCHOOLS

Mornings in Greeley were refreshing. It was hard to enjoy the relative coolness of the evenings because I was usually in the clinic, and the heat was always oppressive there. By nine o'clock the evening breeze brought into town each night the smell of manure, suffocating in its intensity, from the world's largest feedlots just outside of Greeley. Just home from a long day of work, I was especially restless at bedtime and consequently overtired in the mornings. Still, I looked forward to them. The mornings were not really cool, but I usually had an hour or two before I began to sweat again. And the first hour of our work day was often a time of relaxation for us, for we spent part or all of it sitting in the car, talking or thinking quietly to ourselves, as we drove to another town, another school, and another tedious day of one physical examination after another.

On our first Monday together, Karen, Eileen, and I visited the schools in which we would be working. Each of the schools had a special summer program for migrant children, but at that time I was still confused about the funding and organization of each program. We drove first to the school in LaSalle, a few miles south of Greeley, where only one



() Members of "Sweep" team for Title I physical examinations

() Dental students

Figure 1

Migrant Health Agencies and Workers in My Area

(See Appendix A for detailed descriptions of agencies)



Figure 1: A flowchart illustrating the process of data collection and analysis. The process starts with 'Data Collection' and proceeds through 'Data Cleaning', 'Data Analysis', and 'Data Interpretation'. A feedback loop is shown from 'Data Interpretation' back to 'Data Collection'.

The flowchart illustrates the process of data collection and analysis. The process starts with 'Data Collection' and proceeds through 'Data Cleaning', 'Data Analysis', and 'Data Interpretation'. A feedback loop is shown from 'Data Interpretation' back to 'Data Collection'.

program, for school-aged children, was to be held. Like all the Colorado programs for school-aged migrant children, it was funded with Title I--federal--money and administered by the state Department of Education. After introducing ourselves to Barbara, the program nurse, we drove back to Greeley and stopped at an elementary school. Here there was another Title I program, but the school housed a Head-start class, toddlers' groups, and a nursery as well. These programs were also ultimately funded by the federal government but were administered by the Colorado Migrant Council, a non-profit, predominantly Mexican-American organization. As at LaSalle, the Title I program in Greeley had been provided with a full-time nurse, Paula, through the state Department of Health. The CMC was also supposed to maintain a nurse in each of its programs but had only hired nursing students for some schools. At Greeley we met Tim, who had finished just one year of nursing school and had accepted his contract with the CMC under the condition that he would be working under a registered nurse. Now he was frightened by the responsibility with which he found himself and was bitter about the deception.

That afternoon we introduced ourselves at the school in Ault, fourteen miles north of Greeley. We met Dorothy, the Title I nurse, and Janice, another nursing student who was to take responsibility for a large group of infants and toddlers. She was to be supervised by Nina, who had just graduated from the same nursing school that Tim and Janice

attended in Texas. Nina's assignment was to the Ft. Collins school, twenty-five miles to the west of Ault. Both Janice and Nina had heard of some unpleasant interactions between CMC nurses and Student Health Program workers the summer before and, as a result, resented our own team well into the summer. Karen soon understood the basis of their coolness toward us. Although she never discovered just what had happened the year before, she guided us in being diplomatic with them.

From Ault we drove on again to the Ft. Collins school to offer our help because the Student Health Program team would not be arriving there for another two weeks. At dinner, after the long drive back to Greeley, I wondered aloud about what we had accomplished in a day of driving and introductions; but Karen assured me of the necessity out here of just saying hello before bringing up a matter of business.

On my first night in Greeley I had searched for several hours, along dark streets, for a suitable room. Inside every house, it seemed, was a little old lady with a room to rent. Invariably the room was bleak and did not include kitchen priveleges, or, if the room was not depressingly lonely, it had just been snatched up by a summer student. The next morning I was cheered to find a large, sunny room, in a boarding house of sorts, which faced the pretty lawns of the University of Northern Colorado. All the rooms on the floor were about to vacated, and, after

overcoming her guilt at leaving her first lonely landlady, Karen rented two of the rooms for herself and Eileen. I was glad, for I had not wanted to live alone in a strange town in the first place.

Two weeks later, at one of our orientation sessions in Denver, a medical student from a small town in Colorado spoke up. "I have one word of advice for the students from the East," he said. "Slow down." I reflected on his perception of someone like me. At the clinic I had not felt that I was moving too fast, as it was often very busy and the other staff members were usually hustling patients into and out of rooms. But I remembered my impatience when I had been looking for a room with Karen. To me, we seemed to be wasting so much time in prolonged chit-chat with every little old lady we encountered. Although Karen herself was from a large city, she understood from her previous summer in the program the need for slowing down in these towns. As she patiently listened to the would-be landladies, my own brief statements and my desire to end these conversations as quickly as possible, began to seem abrupt in comparison. If Karen had not led me through these first encounters, I am certain that I would not have realized so soon how rude my habitual terseness with strangers must have seemed.

The necessity of driving long distances in our work was obvious. Looking out of the car windows between towns, I saw only fields stretching away to the mountains in the west and the flat horizon in the east. I soon felt the

overlooked and left at intervals for this locality, where I found that the house was empty and that I had not been asked to live there as a friend, but in the first place.

The second letter, of one of our distinguished statesmen in America, a national subject from a small town in Kentucky, reads as follows: "I have the honor to acknowledge the receipt of your letter of the 10th inst. and am glad to hear that I was useful to you, as it was some time ago and the other night I was again thinking of you." I replied on this.

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tyrrany of large distances and lengthy drives, especially when Arnie and I tried to find public transportation between Greeley and Sterling. Since Karen and Sandy both had cars, Arnie had greater need for our car than I did. And because he was responsible for seeing migrants who, lacking a clinic in Sterling, often came to the hospital emergency room with health problems, he would have to stay in Sterling on some weekends. Our hopes sank with each call we made. There simply was no public transportation that I could take from Greeley to Sterling on those weekends, unless I was willing to backtrack to Denver by bus and then take another bus to Sterling--probably a five-hour trip that way, not counting the stopover.

On my first visit to our schools, the nurses asked me to look at a foot laceration, a patch of impetigo, a baby with a cold. Throughout the summer they asked me, when I happened to be at their schools, to examine children they were concerned about and to decide whether the child should be taken to a doctor, or what simple remedy they could administer at school. I had spent my six weeks of pediatrics at Yale on a ward of acutely ill infants and in a newborn special care unit. There I had hardly touched sick children, let alone healthy children. I was never given any training in outpatient pediatrics (The University of Colorado Medical School, I learned, now allows students to spend their required pediatric rotation totally in outpatient clinics, and wisely so.). At the beginning of the summer I did not

know any more than did the nurses about caring for simple ailments. But it was soon clear that I was less anxious about making decisions than were they. The three Title I nurses had just graduated from nursing school, and there they had not learned to make decisions.

Our Student Health Program team had two roles. First, we were to help the school nurses in any way we could. Aside from solving acute health problems, they were responsible for time-consuming screening tests on all the children: height, weight, hematocrit, urine dipstick, vision, hearing, throat culture. Colorado is known as a "strep belt," and many children had throat cultures positive for B-hemolytic streptococci. The nurses had to transport these children to the clinic for Penicillin shots, visit their families in order to take cultures from the entire family (and thus prevent reinfection), and then reculture the children after treatment. Home visits had to be made in the evenings, and they were time-consuming in the extreme because most of the families lived in isolated spots amongst the fields.

Second, our program members were to take responsibility for doing physical examinations on all the school-aged migrant children. In past summers, these had been arranged for the younger children in the CMC programs. A "Sweep" team of pediatricians, pediatric nurse practitioners, and medical students had come out for the day from the University of Colorado Medical Center to examine and plan health care for all the CMC children in each center. Last summer a

medical student had, on her own, examined some of the Title I children as well and found a significant number of abnormal conditions that she felt she would not otherwise have detected. This summer, therefore, the Student Health Program directors charged each team with the task of examining all the children in its area.

The most difficult requirement of our first role was tact. We wanted to ensure that the screening tests were done, but we did not want to harm our working relationships with the school nurses by appearing critical or domineering. Our most uncertain situation was with Janice and Nina. To allow enough time for adequate follow-up care, the CMC Sweeps had been planned for early summer. The visiting pediatricians could assess a child's health more accurately if the results of the screening tests were available; these tests therefore had to be done especially early for the infants and small children. Until the day of the Ault Sweep we were not able to find out from Janice and Nina (without appearing doubtful of their abilities) whether the screening had been completed. But at the Sweep they produced all the necessary information, and our relations with them gradually improved through the summer as they came to see us as helpful rather than critical.

For the first few weeks we continued to go from school to school to help with the screening. I argued with Arnie about my participation in these tasks. He had decided that they were a waste of his time, so while the nursing

students on his team helped with them, he assisted Dr. Thompson at his office. To me it was important not to place myself above the other members of my team. I am sure that, as a woman, I came by this attitude more easily. Other female medical students and I often sense that, for many of our male classmates, male-female role differences have defined certain boundaries between doctor and nurse behavior before they have ever been exposed to medical work. What I have read on medicine in modern China excites me: I have always been more comfortable, and learned more, when status is deemphasized. When there is less to live up to, people more readily admit what they do not know and share what they do know. China's system makes so much sense to me. There good nurses often go on to become doctors, but in the United States training programs are still so rigidly different that such a switch is extremely difficult.

I did not regret my participation in the screening. I enjoyed the good spirit of group cooperation, and, in this informal setting, I discovered some unknown abilities within myself. I developed a routine for explaining to the children why we took blood from their fingers and how their blood count reflected what they ate. We found that the children were much less frightened if we demonstrated first on a teacher they trusted, and so this too became part of our show. I already believed in telling patients as much as possible about their health or disease, and I had often drawn pictures for adult patients to help them understand

my explanations; but I had never tried to explain the mysteries of medicine to children. It was challenging at times, but it strengthened my conviction that just about anything can be explained to a patient's satisfaction if the physician cares to take the time and be creative.

Through the children and their school programs I also learned more about farmworker life. The children were adorable, and many were exquisitely beautiful, with large brown eyes that ruled their little faces and, it seemed, the world. The toddlers and kindergarteners were not afraid of us, probably because they were used to being doted upon by adults--and Mexican-American parents do dote on their little children! Karen showed me how easily I could reduce their fear of procedures, such as having their fingers pricked, by holding them on my lap and comforting them physically. By six or seven the sex roles of their culture emerged clearly in the children: the girls became shy gigglers and the boys rambunctious boasters. By thirteen the children were all working in the fields for the summer. (out of 260 Title I children in our three schools, we examined only one child over the age of twelve), and many younger children worked as well. In our area there were two crops. The hoeing of the beets, in June, was skilled work and done by adults and adolescents. The cucumber pickles ripened in July. Picking them was hateful work, for the cucumbers grow low to the ground, surrounded by thorny vines. After the Fourth of July holiday some nine- and ten-year-olds

did not come back to their classes but went instead to work in the pickles.

When the bulk of the screening tests had been done, we turned our attention to the task of performing physical examinations on so many children. In our area, the three Student Health Program teams--Greeley (three schools), Ft. Lupton (three schools), and Ft. Collins (one school)--decided to work together as a "Sweep" team and to try to cover one school each day. With hundreds of children to examine, it was obvious that we needed more than those of us who already knew how to examine children. I would have to teach the nurses how to do it. In a pediatric textbook I found a clearly written chapter on the pediatric examination and Xeroxed copies for all the nurses. One Sunday evening we all gathered on the floor of Eileen's room to discuss the pediatric examination and to practice the techniques of it. Karen and Eileen had never learned to do examinations. Laurie from Ft. Lupton and Sandy had just completed a nurse practitioner program in which they had learned to examine adults. Carol, also from Ft. Lupton, was only one year into the Child Health Associate program in Denver but already knew, and taught us all, a great deal. By preparing to teach the material, I myself relearned much of what I had forgotten since my pediatric rotation. The other members of our Sweep team had not been able to come down from Ft. Collins for the session; they would be John, just through with his basic sciences half of medical school,

and Debby, also a recently graduated adult nurse practitioner.

As we planned our Sweep strategy, we recognized that we lacked good medical histories for our children. These were as important, if not more so, than the examinations themselves. The CMC had community outreach workers who (more or less reliably according to the individual) obtained medical histories from the parents of the little children; but we had no such information for the Title I children. I decided to try to obtain from the parents a history of serious illnesses in the past and of symptoms they had recently noticed. I also thought it important to inform parents of the physical examinations out of courtesy and to include them in their children's health care (I think that the performance of such procedures in schools may suggest to parents, and rightly so at times, an assumption on the part of health workers that the parents themselves do not want to provide their children with proper health care.). I composed a form to send home with each child, and Karen helped me to make it more understandable to farmworker parents. The Title I nurses were enthusiastic at first, but somewhere beyond its translation into Spanish, the form met a quiet death. We had become too caught up in our immediate tasks to follow through adequately on it. When we examined children in Ft. Lupton, Carol and Laurie reported that the parents there had responded well to a similar form which they had initiated, and I regretted that I had not seen my own project through.

When we began our Sweeps, we consulted each other continually. Many of our decisions about treatment or referral were team decisions out of necessity, not preference. We were forced to put our bits of knowledge together to make sense out of confusing clinical findings, and, in our inexperience, what would have been boringly commonplace to a pediatrician could be quite confusing to us. But we liked these consultations, for we learned from them. All of us soon found doing one examination after another, morning and afternoon, tedious and exhausting, and consultations over problems became, for me at least, a welcome interruption. Now I can laugh at the absurdity of my role as "senior consultant," but at the time it was usually uncomfortable. Often I did not know what to do, any more than the others did, but I would have to come to some decision. On the other hand, I must admit that I sometimes took advantage of my experience, for there were days when I happily checked findings for everyone else and thus avoided doing full examinations myself. Because finding and interpreting eardrums and picking up heart murmurs were especially difficult for the beginners, the rest of us routinely checked ears and hearts for them. We in turn referred too many children to physicians for what we thought might be inflamed eardrums or serous otitis media, and we referred some innocent heart murmurs because we could not be certain of their innocence. We knew that federal money would be wasted on overreferrals, but we felt that our primary debt

was to the children. Few of them received well child care elsewhere, and we did not want to miss any conditions that might have serious consequences. If we had had a physician to supervise us, we would have saved ourselves much time and the government some money. We would have treated the conditions we found more appropriately, and we would have learned more.

By the middle of July we were discouraged. For one thing, the Sweeps were taking enormous bites out of our time and, as they dragged on, we realized that they were keeping us from doing follow-up care on the children whom we had already examined. The school nurses were primarily responsible for follow-up care, but even though each Title I nurse had a helpful aide, they could not get everything done. The children's families had no telephones in their isolated temporary quarters, and a note sent home with a child was useless if a discussion of a health problem was necessary. Many problems, especially those related to nutrition, called for a home visit. Because of the distances involved, one home visit could easily take a whole evening. If a family was not at home, the trip was for naught and had to be repeated on another evening. When Karen, Sandy, and Eileen were not working in the clinic in the evenings, they helped with home visits. Marcia, the nutrition student covering our area, helped when she could, but she had responsibilities in several towns. Home visits could be made on weekends as well, but our team had to spend some weekends in Denver

at program conferences, even though we soon felt that the conferences had less value than the work we might have done instead in Greeley. To my disappointment, I did not make many home visits because I worked three evenings a week in the clinic and was unwilling to give up seeing Arnie on weekends. In the few visits I made, I was able to learn much more about patients' problems and accomplish more patient education through relaxed conversation. I was also able to learn much more about farmworkers' lives and health problems in general. Second-hand pictures of someone's living conditions relate almost nothing when compared to a first-hand experience of a few moments of that person's life. These few visits profoundly influenced my way of thinking about treatment plans for my patients. Daily urine testing for diabetic patients, or hot soaks, for example, no longer seemed easy for patients to accomplish, once I had visited homes without a bathroom or a hot water tap.

By this time the clinic had clearly established itself as another, and major, obstacle to our follow-up care. This also was discouraging to me. The clinic was the logical place to take those school children who needed to see a doctor. Through the children we could meet the migrant parents and encourage them to seek treatment for other family health problems. Their place of treatment would naturally be the clinic. Although there were one hundred doctors in Greeley, only a dozen or so, it was said, would see migrants. The clinic had the added advantages of

strong ties to the farmworker community, a fee of only one dollar per visit, and free drugs.

At the beginning of the summer everyone assumed that the migrant children would be taken to the clinic, but the school nurses were gradually forced to find alternatives. Although families seemed to enjoy the social aspects of waiting at the clinic and complaints about the hours spent thus were almost never heard, for the school nurses the wait was incapacitating. They would take groups of children to the clinic at its opening hour but sometimes wait three hours to be seen. At times nurses had to bring their children back to school without seeing Dr. Barra at all because the school buses departed at four o'clock in order to get most of the children to their distant homes by six.

I really cannot describe the exact nature of the passive resistance which the school nurses encountered at the clinic because I did not observe it first-hand. But the nurses strongly corroborated each other's belief in its existence. Apparently Dr. Barra balked at more flexibility in clinic procedures so that the children might be seen more promptly. For instance, lab tests (hematocrit, urinalysis, height and weight) done routinely on clinic patients were one delaying factor. Insistence on these tests made sense for a patient population receiving sporadic care; but the children had just received these tests at their schools. After continued objections, Dr. Barra conceded that the children could be seen without repeated lab tests at the

clinic if the nurses brought with them their results for each child to be seen that day.

Other problems centered around forms--since the funding for this care was federal and, in addition, channeled through two different agencies, there was naturally a holocaust of paperwork for ever physician-child encounter--and the clinic was apparently overly rigid about these as well. If Dr. Barra's relations with the Student Health Program were any indication of her general tendencies, she probably had not been eager to cooperate with other agencies in the first place. At any rate, the school nurses soon found private doctors who would see the children more efficiently.

This was most unfortunate for me. I would have been able to provide better follow-up care and learn more, if I had been able to carry on with my own preceptor a summer-long dialogue on the cases I had seen in the schools and had then referred. If the clinic had been more cooperative, and if I had not spent so many days on the physical examinations themselves, I could have spent some afternoons in the clinic where, with a bit of advice from Dr. Barra, I could have treated the little patients I already knew. In this way I would have truly and efficiently functioned as their primary care doctor, and both sides would have benefitted--they from continuous care, I from the satisfaction of providing it.

After another week or so of plodding through more

which is the same as the one with the same meaning.

Each child is to read the story.

There is a very good story about the same thing.

Reading the story will help you to understand the story.

There is a very good story about the same thing.

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examinations, we decided that we simply had to use more of our time for follow-up work. Nevertheless, we did in fact almost complete our task, even though some examinations were done very late in July. Out of seven Title I programs in our area, we missed only one class of children in one school. I was doubly disheartened because I was leaving soon and had no hope of seeing before I left how much we had actually accomplished. How many neglected health problems had we uncovered by this tedious work? How well did we solve the problems we uncovered? After I left, Karen, Sandy, and Eileen would be devoting another ten days to follow-up care alone. To get some idea of the end result of my own efforts, I made out a problem-list card for each child in our three schools. Karen, Sandy, and Eileen found the cards helpful in their follow-up efforts, and after they too left Colorado they sent the cards to me.

I have organized the outcomes of the many health problems we encountered, and my impression is that some follow-up care was accomplished for a sizable number of children. Table 1 represents a summary of the data accumulated on my cards.

Karen, Sandy, and Eileen each took responsibility for helping with the follow-up care at one school. Recognizing the difficulty of their work, I made no special request of them for consistency with each other in reporting problems or follow-up. The recording of certain conditions as problems by several different examiners, and by different

Table 1

General Health Data on CMC and Title I Children

	CMC (1 mo.-4 yrs.)		Title I (5-12 yrs.)		
	Greeley (N=37)	Ault (N=62)	Greeley (N=79)	Ault (N=84)	LaSalle (N=97)
<u>Health Problems</u>					
Mean number of problems per child	1.49	1.44	1.18	1.22	1.11
% of problems followed up	83%	79%	84%	67%	74%
<u>Immunizations</u>					
% not up to date	57%	47%			
% of <u>these</u> not brought up to date	No Data	27%			
<u>Throat Cultures</u>					
% positive	27%	37%	30%	44%	15%
% of <u>these</u> with a second positive culture	20%	-	17%	19%	-
<u>Dental Problems</u>					
% needing dental care	5%	21%	43%	49%	27%
% of <u>these</u> not brought up to date	No Data	No Data	47%	37%	19%

school nurses, may also have been quite inconsistent. For example, pediatricians were present for CMC, but not for Title I Sweeps; when we first began our Title I Sweeps we thought that many more children had serous otitis media than actually did, and our skill in recognizing it improved with practice; one nurse felt that it was wrong to enter "lice" on his problem lists (The CMC required that any problem mentioned there had to be transcribed onto computer data sheets which had been developed on a national level to follow migrant children through their schooling in various places, and Tim felt that this information provided fuel for prejudice against migrant children.). The timing of health problems probably caused additional inconsistency in my data, since many children had problems at times other than the day of their physical examinations, and the entering of these problems on my own cards depended on the way in which each school nurse had recorded them. Without belaboring the point further, I must emphasize that I have no way of evaluating the consistency of the data on my cards.

Because many of the health problems listed on my cards are not dated, I cannot calculate how many problems were uncovered by the physical examination itself. I regret now that I did not distinguish these problems when I made up the cards, for I myself would have liked to evaluate more accurately the value of our concentration on the examinations. In addition, we learned at an orientation session of a controversy within the field of pediatrics over the

value of screening examinations for school children in general, and with better data we could have formed a stronger opinion to contribute to the discussion of this issue.

After evaluating health screening procedures much like ours (physical examinations by nurses and a similar battery of lab tests) on migrant children in a California summer school program, Eisner (1972) concluded that a physical examination is not essential to health screening programs. 68 of the 103 children in the study were found to have a total of 117 "health defects" warranting referral of some kind. As in our own experience, most of the detected defects were non-serious cases of mild anemia, vision and hearing defects, otitis, head lice, and upper respiratory infections; but several serious problems were noted and brought under care for the first time. Eisner believes, however, that all of the serious problems detected by physical examination could have been detected by less costly procedures (for example, a computerized heart-sound analyzer to detect pathological heart murmurs but avoid referring innocent murmurs, detection of many conditions simply by questioning parents and teachers, detection of minor problems like lice and respiratory infections through teachers). Of 14 cases referred for possible otitis media, a potentially serious condition, 11 were judged by the evaluating physician in Eisner's study to be overreferrals, whereas 17 children were found by audiogram to have reduced hearing.

Tables 2 and 3 detail the frequency of the health

problems (other than lack of immunizations, positive throat cultures, and dental disease) we ourselves encountered. Problems for CMC and Title I children are presented separately. Because of the presence of experienced pediatricians at the CMC Sweeps, clinically detectable health problems were probably assessed and recorded more accurately for the younger children.

Nutritional problems. Anemia was the most common nutritional problem. These cases were easily detected and handled by the school nurses, who with our help obtained hematocrits on all the children. Most of the cases of anemia were mild and were treated with daily iron sulfate administered by the school nurses. When possible, hematocrits were rechecked a few weeks later and home visits to discuss nutrition were made.

Dr. H. P. Chase, a pediatrician who participated in the CMC Sweeps and in the administration of the Student Health Program, had done research previously on nutritional deficiencies in Mexican-American farmworker children and believed Vitamin A deficiency to be prevalent in this population. He alerted us to its clinical signs, and we recorded a number of cases as possible or probable Vitamin A deficiency. But whether most pediatricians would agree that these subtle signs did indeed represent deficiency, I do not know.

We found 7 Title I children and 1 CMC child below

Table 2

Health Problems of CMC Children
(N=99)

	<u>No. of Cases Followed Up</u>	<u>No. of Cases Not Followed Up</u>
<u>Nutritional problems</u>	<u>19</u>	<u>17</u>
Vitamin A deficiency	5	7
Vitamin D deficiency	1	2
Vitamin C deficiency		1
Possible general deficiency		1
Below 3rd %ile in height		1
Below 3rd %ile in weight	1	
Below 3rd %ile in height & weight		1
Decreasing height growth		2
Failure to thrive	2	
Possible protein deficiency	1	
Decreasing weight 2° to inadequate protein intake	1	
Anemia	8	2
<u>Skin problems</u>	<u>37</u>	<u>7</u>
Ringworm (tinea corporis)	1	1
Diaper rash (candidal diaper dermatitis)	7	
Impetigo	7	
Eczema	2	1
Thrush (oral candidiasis)	1	1
Heat rash (miliaria)	1	1
Herpes simplex gingivostomatitis	2	
Furuncle	1	1
Folliculitis	1	
Laceration	1	1
Infected laceration	2	
Head lice	11	1
<u>Respiratory tract problems</u>	<u>23</u>	<u>2</u>
Upper respiratory infection	15	
Pharyngitis	1	
Tonsillitis	5	
Viral pneumonia	1	
Possible pertussis		1
Possible bacterial rhinitis		1
Frequent nosebleeds	1	

Table 2 (continued)

	<u>No. of Cases Followed Up</u>	<u>No. of Cases Not Followed Up</u>
<u>Ear problems</u>	<u>11</u>	<u>2</u>
Infectious otitis media	6	
Serous otitis media	2	2
Scarring of eardrum	1	
Cerumen impaction with hearing loss	1	
Otitis externa	1	
<u>Eye problems</u>	<u>3</u>	
Conjunctivitis	3	
<u>Gastrointestinal problems</u>	<u>13</u>	
Gastroenteritis, probably viral	11	
Bacillary dysentery (Shigella)	2	
<u>Heart problems</u>	<u>1</u>	<u>1</u>
Possibly pathological murmurs	1	1
<u>Other health problems</u>	<u>6</u>	<u>1</u>
Adherent foreskin	1	1
Foot turned in	1	
Chickenpox	4	
<u>Problems by history only</u>	<u>1</u>	<u>1</u>
Arthritis and pedal edema	1	
Urinary frequency and bad odor		1
<u>Problems of social development</u>	<u>3</u>	
Unusual posturing	1	
Poor social development	2	

Table 3

Health Problems of Title I Children
(N=260)

	<u>No. of Cases Followed Up</u>	<u>No. of Cases Not Followed Up</u>
<u>Nutritional problems</u>	<u>24</u>	<u>13</u>
Vitamin A deficiency	3	3
Vitamin D deficiency	1	
Below 3rd %ile in height		1
Below 3rd %ile in height and weight	6	1
Low weight for size	1	
Failure to thrive	1	
Obesity		5
Anemia	12	3
<u>Skin problems</u>	<u>48</u>	<u>11</u>
Head lice	16	5
Athlete's foot	11	3
Ringworm (tinea corporis)		1
Impetigo	3	1
Rash, etiology unknown	2	
Blisters	3	
Multiple insect bites	3	
Lacerations	2	
Infected lacerations	2	
Sores from ill-fitting shoes	2	
Preauricular sinus	1	
Plantar wart	1	
Peeling of skin of hands	1	
Petechiae	1	
Furuncle		1
<u>Respiratory tract problems</u>	<u>37</u>	<u>15</u>
Pharyngitis	22	9
Tonsillitis	12	6
Cough	1	
Congestion of lungs	1	
Paroxysmal coughing with cyanosis	1	
(Common colds were not reported)		

Table 3 (continued)

	No. of Cases <u>Followed Up</u>	No. of Cases Not <u>Followed Up</u>
<u>Ear problems</u>	<u>25</u>	<u>3</u>
Infectious otitis media	3	
Suspected infectious otitis media	4	1
Serous otitis media	8	2
Perforation of eardrum	3	
Scarring of eardrum	1	
Inflammation of ear canal	1	
Fungal infection of outer ear	1	
Foreign body	2	
Hearing loss 2 ^o to cerumen impaction	1	
Hearing loss	1	
<u>Eye problems</u>	<u>16</u>	<u>2</u>
Poor vision	9	5
Conjunctivitis	4	1
Strabismus	2	1
Suppression of one eye	1	
<u>Gastrointestinal problems</u>	<u>1</u>	
Gastroenteritis	1	
<u>Heart problems</u>	<u>2</u>	<u>3</u>
Possibly pathological murmurs	7	3
Fibroelastosis with mitral insufficiency	1	
Septal defect with mild pedal edema	1	
<u>Problems of genitalia</u>	<u>13</u>	<u>3</u>
Adherent foreskin	11	2
Undescended testis		1
Possible vaginitis	2	
<u>Muscle, bone, joint problems</u>	<u>7</u>	<u>4</u>
Rheumatoid arthritis	1	
Fracture of arm	1	1
Ganglion	1	
Trauma to fingers	1	
Hemihypertrophy		1
Flat feet		1
Toes turned in		1
Back curvature	1	
Limp	1	
Arthralgia	1	

Table 3 (continued)

	<u>No. of Cases Followed Up</u>	<u>No. of Cases Not Followed Up</u>
<u>Other health problems</u>	3	
Fever	1	
Hypertension	1	
Cerebral palsy	1	
<u>Problems by history only</u>	5	1
Frequent nosebleeds	1	
Abdominal pain	1	
Flank pain	2	1
Urinary frequency	1	
Convulsions	1	
<u>Problems of social development</u>	1	1
Brain damage by psychological testing		1
Hyperactivity	1	

the third percentile for both height and weight. There is controversy over whether such cases represent true nutritional deficiency, as Dr. Chase tends to believe, or the smaller stature which, others maintain, is genetically given to Mexicans. When home visits were made in these cases, the outcome was generally recorded as "Entire family is small," and no obvious nutritional deficiency was found. In addition, however, there were 3 definite, previously diagnosed cases of failure to thrive, a CMC child whose weight decrease was reversed by increased protein intake at school meals, an infant with obvious deficiencies of Vitamins C and D, and several other cases which strongly suggested nutritional deficiency. In a later chapter I will discuss some research on nutritional deficiencies in migrant farm-workers in the United States.

No follow-up care was initiated for 5 cases of obesity because, within the Mexican-American culture, fat children are considered healthy.

Skin problems. Head lice were the most common in this category but, of course, not the most serious. As with cases of anemia, these were easily handled by the school nurse and the teachers. The children swam and had showers at school, and Kwell shampooing was easily added to their routine. Although most of the cases on my cards were recorded as resolved, my memory suggests that many cases and recurrences must not have been recorded. Chasing lice out of an entire school required great perseverance, probably

because a few children were borrowing from non-Kwelled heads at home. Attempts were made to block this path of reinfection by sending Kwell home with children for use on all family members.

A number of boys at the Greeley school had what appeared to be "athlete's foot". Most of these responded quickly to antifungal ointment administered by the school nurse.

11 cases of impetigo were recorded. Since streptococcal infection of the skin is known to be associated with acute glomerulonephritis, only small, single patches were treated topically. Most children with impetigo were taken immediately to a physician for Penicillin injections. To our knowledge, we had no sequelae in our own children, but we did see a boy in Ft. Lupton who had been treated for impetigo earlier in the summer and now had acute glomerulonephritis.

Diaper rash was common in the infants. All these cases were cleared by instructing the day-care workers in proper care and applying topical agents. Home visits were supposed to be made to prevent recurrence when the summer program ended, but I have no information on whether these were actually accomplished.

Respiratory tract problems. Colds, pharyngitis, and tonsillitis were very common. Throat cultures were routinely done in these cases because of the high incidence of

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streptococcal infection. Children with positive cultures received Penicillin injections, and the cases of viral etiology resolved quickly without treatment.

It is commonly believed by migrant health workers that infectious disease has a higher incidence in the migrant than in the general population. Crowded conditions in their homes and travel vehicles probably do increase the spread of infectious disease; but for our children, as for all children, a certain amount of infectious disease was obviously spread through contact at school.

Ear problems. All 9 cases of infectious otitis media were treated adequately with antibiotics. We also referred 5 Title I children for suspected infectious otitis media, and most of the cases seen by a physician were overreferrals. Serous otitis media was also commonly noted, but many of our Title I cases were, again, overreferrals. Neglect of ear infection was, however, a problem in our migrant children, for we saw 3 children with perforations of the eardrum and 2 cases with significant scarring on inspection. Fortunately only 3 children in our schools had hearing loss upon testing, and 2 of these were easily resolved by removal of cerumen impactions. When I had helped with screening at the Ft. Collins school early in the summer, a teacher sent to the nurse a twelve-year-old boy who, she wisely perceived, was not slow, as she had at first thought, but could not hear. I looked into his ears

and found them both infected, with one draining pus through a large perforation.

Eye problems. 14 Title I children were found to need glasses. Of these, only 9 cases were considered completely resolved. A few others had received glasses but had not had their adjustment to them adequately checked before they moved away. It was fortunate that Title I money could be used to purchase glasses for the children. During the summer I met a few adult migrants who did not have the glasses they needed because, for adults, no money was available to defray their high cost.

Gastrointestinal problems. At Ault School a quickly resolving gastroenteritis caused a small epidemic of diarrhea amongst children and staff. 2 cases of persistent diarrhea in CMC children at Greeley were eventually diagnosed by culture as bacillary dysentery (*Shigella*), and 1 child required a week of hospitalization. Although I found no other cases of diarrhea recorded on my cards, I remember that in July several other infants and toddlers at Greeley did have bouts of diarrhea. These may well have been related to the *Shigella* which was finally cultured out.

Heart problems. We made several overreferrals for heart murmurs because we did not want to miss any pathological murmurs. 3 of the 13 referred murmurs in Title I children were never subsequently evaluated by a physician, and 1 child, believed by pediatricians at the CMC Sweep to

have a pathological murmur, moved away before he was evaluated by cardiologists in Denver. 1 boy with a loud heart murmur and slight pedal edema denied at first that he had ever been sick, then remembered: "Oh yeah, once I was in the hospital for a hole in my heart." He was referred to the clinic, where he was judged to be doing well and under adequate care at home in Texas. A girl who was sent to the emergency room with a fractured arm produced, upon her arrival there, bottles of digitalis and Lasix, which she said she took daily. The school nurse soon discovered that the outreach worker who had enrolled the child at school had received information from her parents about her heart condition but had neglected to give it to the nurse. This information could have been vital, for although the child was doing well at present, her condition (fibroelastosis, with mitral insufficiency) was extremely serious and she had been in congestive heart failure several times in the past.

Problems of genitalia. Mexican-American boys are not circumcised, and we saw a number of children whose foreskins could not be fully retracted. Since this condition results from poor hygiene, follow-up care consisted of a talk on proper hygiene by a male teacher and home visits. While 11 home visits were successfully made for the 13 cases in Title I boys, we could not evaluate the effect of the visit on the health problem itself. For 2 CMC children, follow-up care included gradual retraction of the foreskin

at school.

Other serious conditions. A twelve-year-old girl with rheumatoid arthritis was being followed at the Ft. Lupton clinic, where she was known from the previous summer. Her main problem was not the disease itself; a doctor in Mexico had inappropriately prescribed steroids for her and she had become somewhat Cushingoid. Although she denied taking steroids at that time, her doctors at Ft. Lupton suspected that she had become dependent on the steroids and was in fact still taking them.

A twelve-year-old boy with cerebral palsy was attending school in this country for the first time. Until this year he had lived in Mexico with his grandmother, who apparently infantilized him because of his handicap. In the spring he had come to Colorado to live with his mother, who had settled out near Greeley, and he had recently had bilateral tendon-lengthening operations through the state Handicapped Children's Program. At school he had daily physical therapy sessions to improve his walking, and the school nurse spoke regularly with his mother.

Problems of social development. An infant was felt by pediatricians to have unusual posturing of its limbs, probably due to infrequent holding. A pediatrician discussed the problem tactfully with the mother, who happened to be one of the day-care workers at the school.

A four-year-old boy was noted to be extremely spoiled

and unable to play with others. On a home visit the mother readily told the CMC nurse that at two years of age this child had smothered his baby sister. Since that time she and her husband had resented and feared him, but they attempted to hide these feelings from him by spoiling him materially. They also wanted to have more children but were afraid to. The CMC nurse was able to arrange for a social worker from the Public Health Department to visit the parents and help them with their conflicted feelings.

Immunizations. As Table 1 shows, I have estimated that 57% of the CMC children at Greeley and 47% at Ault were not up to date on their immunizations. Because of inconsistencies in obtaining histories from parents and in noting them on problem lists, these figures are quite approximate, but their general range is probably correct. While many children had received a few shots, we also saw some one-year-old children who still had not received any. The direct cause for these children's lack of protection is neglect by public health officials in their home towns in Texas. I learned this summer that until a few years ago, children could attend grade school in Texas without any immunizations. Outbreaks of polio and diphtheria had finally induced a change in law. For this reason immunizations were not a problem in our school-aged children.

School nurses administered immunizations and attempted to bring children up to date as well as possible

within the time limits of the summer program. At Ault 24% of the CMC children who originally needed immunizations were reported not yet up to date by August 10. I do not have similar data for Greeley, but I am sure that the percentage of children still without adequate protection would be much higher than at Ault. Tim was inexperienced at giving immunizations and remained fearful, even though Paula, the Title I nurse at Greeley, was quite willing to supervise him. When we finally began to devote more time to follow-up care at the end of July, we discovered that Tim had procrastinated throughout the summer and thus had missed the opportunity to give to many of these children the series of immunizations they could have had.

Throat cultures. Because of Colorado's reputation as a "strep belt" and the crowded conditions under which migrant families live, an all-out battle against streptococcal infection was fought in the schools in the schools in the hope of protecting these children from rheumatic heart disease and other serious sequelae. A routine throat culture was done on all children. Since many children with positive cultures were asymptomatic (those who were symptomatic are already represented in Tables 2 and 3 as cases of pharyngitis and tonsillitis), I have separated positive throat cultures from the general category of health problems. As Table 1 shows, the percentage of children with positive throat cultures ranged from 15% to 44% in the five

programs. These children all received Penicillin injections promptly or, in a few cases of suspected Penicillin allergy, a course of antibiotics. The school nurses also made home visits diligently and either took throat cultures themselves from all family members or referred them to the clinic. In two of the programs, all treated children had negative post-treatment throat cultures and no recurrence of streptococcal infection, but in the other three programs about one-fifth of the originally treated children had either positive post-treatment cultures or a streptococcal infection later in the summer. Because of the high incidence of streptococcal infection shown to exist in these children, and because of the poor health care they are likely to receive if they develop sequelae, persistent follow-up care seemed worthwhile.

Dental problems. During our Sweeps we checked children for dental disease. The percentages reported in Table 1 of children needing dental care were, in the Title I programs, 43%, 49%, and 27%. The Title I children were also checked early in the summer by a team of dental hygienists, who assessed their degree of need for dental work. We found that a number of children with suspected caries had not, in fact, been referred by the hygienists for dental care. While our dental assessments may have been inaccurate, I think that the discrepancies represented, rather, the tendency of the hygienists not to refer children with milder needs

because they knew that all the children could not be seen by the available dentists. Many children had serious needs and, as the worst cases went off to the dentist in the first days following the hygienists' visit, we regularly saw bloody-mouthed children, now minus their rotting or infected teeth, crying in the nurses' offices.

As Table 1 shows, from 19% to 47% of the children who needed dental care did not receive it. Most of the Student Health Program teams included a dental student who, under a dentist's supervision, saw migrant children and adults. Because the clinic had not yet hired its full-time dentist, the dental student originally assigned to our team was sent elsewhere. A Greeley dentist was working part-time at the clinic dental unit, and some children were taken there for care. Others were taken to private dentists who set aside certain times for these children. Had we had a dental student, more children and adults could have received dental care, and we could have learned more about dental disease. Despite the constant and varied medical problems we encountered, we all agreed that these children's most glaring need was for dental care. Our nights in the clinic, where we saw adolescents with infected teeth and gums and adults with prematurely, unnecessarily toothless smiles, reinforced our anger over these children's inability to have dental care because of their parents' poverty.

Eisner's second, and most important, conclusion is

that children who go without necessary medical treatment usually do so because of a failure of follow-up, not of case-finding. In that study only 44% of the 117 defects received diagnosis or treatment in the four-month period following screening. Of the 68 children referred, only 43% were considered completely successful referrals. Furthermore, when Eisner looked more closely at referral patterns, he found that many potentially serious conditions did not reach treatment.

Eisner's conclusion may have an important lesson for the Student Health Program. Perhaps we would have used our time much more effectively in visiting the parents of our children, conferring with their teachers, and planning follow-up care.

As Table 1 shows, the percentage of health problems (other than lack of immunizations, positive throat cultures, and dental problems) which had either resolved or had been properly referred to a physician by August 10, or for which a home visit was made when appropriate, ranged from 67% to 84% for the five programs in our area. In terms of successful follow-up, however, these figures are optimistic in the extreme. Many problems, such as respiratory tract infections and gastroenteritis of viral etiology, resolved on their own and needed no follow-up care. Some problems which had not resolved by August 10 were properly referred to physicians; but whether these referrals resulted in successful treatment is not known. Finally, for a number of

different health problems many home visits were actually made, but we had no way of knowing whether the advice given on such visits would ever be put into practice by the children's parents.

In a few of the cases in which families moved away before follow-up care had been given, the problems were referred to the child's next school through a computerized data bank for migrant children. Although some of these cases may eventually be successfully treated because of these referrals, I classified these problems as not receiving adequate follow-up care. In our own school nurses' experience it was extremely difficult to obtain information from this computer system, since it is still in the development stage.

It is interesting to note that the CMC children had more health problems per child (1.44 and 1.49) than the Title I children. Did the older children actually have fewer problems? Probably so, especially since the mean number of problems per child decreased (as we gained confidence and made fewer overreferrals) from 1.22 at Ault, the first school where we examined Title I children, to 1.18 at Greeley and down to 1.11 at LaSalle, the last school where we examined children. The school-aged children in Eisner's study had a similar average of 1.14 defects per child, and this figure, like ours, represents some overreferrals as determined by physicians. If our assessment of health problems was of reasonable quality, and I think it

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was, then there is a valid basis for the current policy in Colorado of using available physician services for the younger children.

Migrant children of every age deserve high-quality health care, and ideally they should all have the attention of pediatric nurse practitioners or pediatricians at least once a year. But if manpower and funds for migrant health care are no greater in Colorado next year, next summer's Student Health Program teams could use their limited time more wisely than we did. I would recommend that they not stray from the schools in their own immediate areas and that they devote most of their time to helping the school nurses in their time-consuming tasks of establishing helpful relationships with the children's families, visiting classrooms and conferring with teachers regularly to detect health problems, and coordinating and accomplishing follow-up care. Perhaps the Student Health Program workers with pediatric examining skills could screen the children in their areas for heart murmurs and ear infection only. All the health workers in our area gained skill and knowledge from our Sweeps. And while I will always be eager to blur professional boundaries again, we could have learned just as much from each other by focusing our sights on evident health problems rather than by looking for obscure ones.

A further conclusion by Eisner is, again, pertinent to our own experience:

One important administrative factor contributed to inefficient use of the screening team and to poor

follow-up. This was the separation of responsibility for health assessment from the responsibility for follow-up. The health assessment was done by teams outside of the normal health care channels. Neither the provision of a coordinator nor of a supervising nurse succeeded in integrating the health assessment into the existing nursing or public health nursing programs of the various communities. Implementing the referrals from the screening teams became additional burdens for people who were already busy with other tasks.

Although our Sweep team was not totally unfamiliar to the school nurses, as were the screeners in Eisner's study, our time commitment to the Sweeps functionally separated us from the nurses in exactly the same way. In retrospect, we should have anchored one Student Health Program nurse at each school to form mini-teams with the school nurses. The nurses from our team could then have served as efficient links to those of us--our area nutritionist and community health educator, and myself--who had to cover more than one school. Had my preceptor been more cooperative with the school nurses, I would have provided the efficient link between diagnosis and prescription at the clinic as well as follow-up care at the schools.

In his study, Eisner also concluded that the primary cause of failure of follow-up was migration. Although this was quite foreseeable in a migrant population, local health facilities nevertheless handled referrals without a sense of urgency. He cites a similar program in California, informally reported by the Fresno County Department of Education, in which 76% of the defects found by screening were corrected because project nurses vigorously pursued

follow-up care. In our own experience, migration prematurely interrupted many plans for follow-up care, but rarely could the failure be attributed to a lack of sense of urgency. With the exception of Tim, who continued to sink periodically into discouragement over his unwished-for responsibility, our school nurses gave persistent and vigorous chase to their children's health problems, but they needed more runners.

We had another goal in mind as we worked. We cannot estimate its accomplishment, let alone measure it with numbers. As we examined children, we included as much health education as time and interest (on both sides, for I must admit that, at least for me, boredom sometimes stifled my interest) would permit. To judge from their wide-open eyes as they heard their own heartbeats, from their eager questions, and from their laughter at recognizing us in vegetable disguise in nutrition skits, I think that we instilled in many children a more pleasant mental association to the idea of health care than they would otherwise have had. This was an important goal for us, for distrust of health care providers, so often justified, helps to keep many farmworkers in ill health and unnecessary discomfort. We wanted our children to grow up believing that they had a right to understand health and disease, that they had a right to expect fine health care delivered with respect. Only the future can tell us whether children like ours will demand, and receive, the health care they deserve.

Chapter 3

THE HEALTH TEAM

Whatever else goes into it, "health care" eventually reduces to individuals and their interactions. As Karen, Sandy, Eileen and I worked together, we began to understand some ways in which our personalities and interactions shaped the health care that emerged from our team. If we had all been more assertive, for example, we might have been moved earlier by our own feelings of discouragement to change our goal from physical examinations to follow-up care. If we had had more physical stamina; if we had known more; if we had been more sensitive to each other's and our patients' needs; if we had wasted less energy on team tensions we never discussed--so many strengths and weaknesses in us, and so many chance combinations of personalities and circumstances, made our work what it was.

From our position we could see that the personal anxieties of Dr. Barra and Tim, in particular, were holding migrant health care in our area below its full potential. But it was harder to see how our own anxieties might be hindering our team's efforts. What was hardest of all was confronting each other about ways in which we were not working well together. At an early orientation session in Denver our program directors had tried, and failed, to

provoke a discussion of team dynamics. They had emphasized the importance of working out interpersonal difficulties as they arose. Everyone had agreed that this seemed wise, but no one had been stimulated by abstractions. When I left Greeley several weeks later, our own team was just arriving at the point of constructively discussing our interactions and our subsequent accomplishments. We had to know each other first, of course. In every such beginning, when we know people slightly but must work with them closely, they easily mushroom into the ogres and godmothers of the fantasies which steal along the edges of our tasks. But when real knowledge of each other, and trust, develop, there can be discussion of false expectations.

We never really argued about our tasks. For most of the summer, our prescribed work at the schools and the clinic¹ left us little time to consider other projects. When, out of our common discouragement, we raised questions about our priorities, we did begin to talk about ways in which we might have been more effective. Sandy was angry over the fact that Karen, Eileen, and I had defined our priorities before she joined us. Sandy had had special training in community health nursing, and she felt that she had not been given an opportunity to use it. Karen was angry, however, that Sandy had not made any effort herself to apply her skills. But even these perceptions were never fully discussed. With more time, we would have been able to talk more openly about our angers at other team members. Then

we could have helped each other to recognize personal anxieties and overcome them in the interest of common goals.

Karen, Sandy, and I all felt tense when we worked with Eileen, and our tension certainly detracted from our enjoyment of our work. Eileen worked hard, though, and I do not know if she actually hindered our team's work. I was not as tolerant of Eileen as Karen and Sandy were (perhaps because I tend to set my standards for myself, and everyone else, too high), and I probably worked less well with her than they did. With time, we might have learned to reduce the tension of working with Eileen; but I am not sure that we could ever have resolved it, and I would not choose to work with Eileen again. I have not written very much about Sandy because I did not get to know her well. Even so, I can imagine myself working effectively with her on an on-going health team. Karen and I used to joke about the places and ways in which we would work together in the future. Although geography will probably keep us apart, I cannot imagine anyone I would rather work with on a health team. She showed initiative in planning health care and sensitivity in carrying it out. I have had too little health team experience to know how important friendship is in the accomplishment of team goals. I do know that my friendship with Karen greatly enriched the health team experience I had, and in our friendship I learned more about the values I would bring with me to any health team.

I can say little of health team experiences in

general by picking out a few strands from the web of words, gestures, and unspoken feelings of our team experience. In fact, my own experience has taught me how important it is not to generalize. On the other hand, I did leave Colorado with some generalizations for myself. I had gone there eager to work on an interdisciplinary health team, and I left even more eager. I also left with a reconfirmed belief in the pleasures of working with other women. In medical school I had experienced neither interdisciplinary cooperation nor the working-day company of women (In an entire year of required clerkships I had worked for only two weeks with another female medical student.), and it was not with pleasure that I returned to the status-conscious "one-ups-manship" of Yale. By the time Arnie and I left Colorado to visit the residency programs to which we were applying, we were both looking for a program in which we could again be members of interdisciplinary teams. We were disappointed to find that none of the Family Practice residencies had thus far integrated a successful team approach into its training, but our two months' team experience was so positive that interdisciplinary teams now permanently inhabit our imaginings of our future careers.

Karen, Sandy, Eileen and I were all women, but we had important interactional problems that revolved, I think, around our ideas of women. From my own perspective I have come to feel that in this society and at this time of change, the relation between sex-role differentiation and

initiative and authority in tasks is important to consider. After my own intimate struggles with activity versus passivity in every aspect of my life, including my role as a student in the extremely sex-differentiated world of Yale Medical School, I was glad to work closely with nurses at last and to understand their experiences. And because Karen, Sandy, and Eileen experienced themselves differently as women, they brought very different expectations to their work.

Karen

Karen's confidence contrasted with the timidity of most of the nurses I came to know through our work. She had been working in intensive care units since her graduation, and before coming to the Student Health Program she had spent a summer in a busy and poorly staffed emergency room in the Rio Grande Valley. There she had first come to know the emotional warmth and economic poverty of the Mexican-American farmworkers. At this early point in her career Karen made decisions readily, and she recognized that this skill was not taught in nursing school or promoted in ordinary nursing work. Both Sandy and Eileen made jokes with Karen all summer long about "Nancy Nurse", the sweet, obsequious girl of nursing-school mythology; but at the end of the summer Karen confessed to me that she felt somewhat bitter over the lack of initiative they had shown. It was true that Karen had the best understanding of the program's potential and its

complex interactions with the other migrant agencies. As a coordinator for the North Central Colorado area, she had an added responsibility for some area-wide decisions. But within our own team Eileen and Sandy almost always waited for Karen to take the lead, even when Karen was consciously waiting them out.

Before Karen, I had not known any practicing Catholics well. She had been in parochial schools from the day she started kindergarten to the day she received her nursing degree, but her high school education had been shaped by the newer trends within the Catholic Church. Now, in important ways, her view of the world was much like mine. Through our work we also met Sister Catherine, a Mexican-American nun who was working with the Migrant Ministry. Once I had adjusted to the idea that this delightful young woman, who drove around in sleeveless dresses doing free-wheeling social work with the migrant families and danced with seminary students at church fiestas, was indeed a nun, I saw that my idea of the Catholic Church was quite stereotyped. Father Duffy was a priest, but he had a degree in social work as well; Ricardo, a seminary student from Texas who was working with Father Duffy for the summer, was studying social work as well as theology. By the end of the summer I realized that rarely had I met people with a more sincere interest in social change or with a greater willingness to learn how to effect real changes for individuals in need of help. Their dissatisfaction with the Church as a

powerful institution with a stake in resisting social change was not so different from my own frustration with wealthy and powerful institutions.¹

Karen had a wonderful sense of the conflicts and emergent centers of her being. She had thought of going to medical school, for she was not satisfied with her nursing work, but she had decided that she did not like to study enough to enjoy it. She had also looked beyond the life of a medical student and had realized that there was much in a doctor's life that would press her away from her desire for close relationships with friends and patients. We knew the same conflict. Now Karen was defining for herself what she did want, and finding it. In the fall she would be going back to college so that she could go on to graduate school, perhaps in public health nursing, and more challenging work.²

Karen and I valued our own ideas, and we discussed our thoughts about our work with little hesitation. Neither of us was afraid to question the other's suggestions because we knew that we were not threatening each other's sense of worth. But perhaps there are two ways of looking at our relationship. I could say that we recognized in each other the same confidence and were therefore not afraid to be honest with each other. Or I could say that we were simply very lucky that our values were so alike, and that we were able to be honest with each other only because what was important to one of us was also important to the other.

I often wonder about this.

In medical school I have worked with many people who seem to close out of their minds so much of their inner, emotional richness. These people strike me as being dishonest with themselves, unwilling to know their own complexity or to live in the discomfort of conflicts. I often talk about these seemingly closed-off people with my friends-- with the people who seem to me to be able to confront their own intricacies more fully. And yet sometimes, in the middle of these conversations, I feel preposterous. I suddenly have a vision of the person we are discussing, and in that vision he is discussing me, and people like us, with his friends. Probably they feel just as we do and say that we have missed the boat somehow by thinking or acting as we do. Probably they have the same convictions about the honesty of their friendships and their honesty with themselves. Perhaps my whole idea of honesty with oneself is a farce. Perhaps my relationship with Karen was "honest" only because we shared important values and structured our worlds similarly. I felt that there was depth to our relationship, but perhaps that depth was illusory, a misconception built out of the echoes of our emotions, each to the other.³

Sandy

I would have liked to have known Sandy better. We were in Greeley together for only six weeks, and for two of

those weeks Sandy was so woefully ill with a triple whammy of tonsillitis, gastroenteritis, and fever that she was forced to stay in her little basement apartment rather than go out to work with us. My first impression of her, when we met two weeks before she joined our team, was that she was afraid of other people. There was some truth in this, and Sandy herself knew it and could talk about it. But when she did come into our team, she came in very well. Some of her jolliness derived, I think, from her fear of being known too well, but she did add a great deal of fun to our work.

In her work Sandy seemed to think of herself as competent. Although she did not actively look for responsibility, she was comfortable with it when asked to take it. When we began to understand late in July that Tim was barely trying to follow his children's health problems, Sandy used the joking-around relationship that Tim already enjoyed with her to get him to help her accomplish some real work. Although she tended to be easily frustrated by problems, there were also an independence and straightforwardness in her which I was coming to know. These I found to be very valuable qualities in a coworker. With a little more time Sandy would, I think, have felt less anxious with us and more involved in our work. As a result she would have undertaken her own work with more enthusiasm and might have contributed her special skills in organizing health care at a community level.

Eileen

Eileen was different. Her background was more like mine: Jewish, from the East, her father a professional. She had graduated from college a year ago, had finished one year of nursing school, and was planning in another year to go on to a graduate nursing program of some kind. But the many ideas she debated aloud about her future career possibilities somehow paled beneath her desire to get married. At home her father had played the petty tyrant, and worse. Eileen laughed off his manner, but the rest of us were struck by the constant and intense criticism on which she had been reared. Her perpetual efforts to please, to jump before our wishes were out of our mouths, aggravated us. With men she was even more subservient, more admiring, and often infatuated. Her definition of herself was not based on her own sense of her capabilities but on the judgements which others made of her capabilities. Consequently she was always nervous with other people. Her movements were brusque, jerky, completely graceless; her speech was staccato and, especially with patients--of whom she was still terrified--as business-like as she could make it. She was without the personal warmth which put our patients at ease. Of course she meant to carry off these situations in just the opposite way. She meant to succeed with patients, with everyone. At heart she was very kind, and she was diligent in her efforts to help others.

Karen, Sandy, and I tried to build up Eileen's

1. The first thing I noticed when I stepped out of the car was the cold. It was a sharp, biting cold that seemed to penetrate to the bone. I shivered as I walked towards the building, my hands tucked into my pockets. The air was thick with the scent of coal smoke and the distant sound of factory whistles.

2. As I entered the large hall, I was struck by the silence. The room was vast, with high ceilings and rows of wooden benches. A few people were scattered throughout, some standing near the entrance, others sitting on the benches. The atmosphere was somber and quiet.

3. I walked towards the front of the hall, where a man in a dark suit and a white shirt was standing. He had a stern expression on his face and was looking at me. I stopped in front of him, feeling a bit nervous. He spoke to me in a low, gravelly voice, his words echoing in the large space.

4. He told me that I was to give a speech. I was surprised and a little bit scared. I had never given a speech before, and the thought of standing in front of so many people made me feel uneasy. He encouraged me, however, saying that I was the only one who could do this.

5. I took a deep breath and stepped up to the small platform at the front of the hall. The man in the suit stood next to me, his hand on my shoulder. I looked out at the audience, which was now filling the benches. They were all looking at me, their faces a mix of curiosity and anticipation.

6. I began to speak, my voice trembling at first but growing stronger as I went on. I talked about the struggles of the workers, the long hours, the low pay, and the lack of rights. I spoke with passion and conviction, my words filling the hall.

7. As I finished my speech, there was a moment of silence. Then, the audience erupted in applause. It was a loud, enthusiastic applause that filled the hall. I looked back at the man in the suit, who was smiling at me. He gave me a thumbs up, and I felt a sense of accomplishment.

8. I walked back down the platform and towards the audience. They were still clapping, and some were standing. I felt a wave of relief and pride wash over me. I had done it. I had given my speech, and it had been well-received.

9. The man in the suit walked towards me again, this time with a more relaxed expression. He shook my hand and said a few words of encouragement. I nodded, feeling a bit more confident now.

10. I walked back to the car, my mind racing with thoughts of what I had just done. It was a strange experience, but I felt like I had made a difference. I looked back at the building one last time before getting into the car.

confidence in herself. At first I was able to speak honestly to Eileen about her obsequiousness and nervousness; we were all comfortable, at first, with telling her to calm down or to stop doing things for us which we would rather do ourselves. Along with this we had many discussions about the directions of our lives, our priorities, our values. After a month or so, however, we all became increasingly aggravated, and often subtly angry, with Eileen. But we tried to keep this undercurrent of emotion out of our interactions with her. Her need for inferiority was much too strong and, far from gaining self-confidence, she seemed to show a greater need to earn criticism. She became more nervous, more clumsy, more stammering.

Like many young people from New York City, Eileen had had little opportunity to drive a car. It was important to our work that she be able to drive by herself to the LaSalle or Ault schools, or to a family's home, since we anticipated that we would often accomplish more by dividing our tasks (As it turned out, the physical examinations took up so many of our available days that we did not often split up.). At the beginning of the summer Eileen agreed with us that she should do most of the driving so that she would gain experience and confidence. But her driving did not improve. On the contrary. She became more nervous about driving, her driving became more dangerous, and we were forced to criticize her more for the sake of our safety. Finally she refused to drive.

Although Eileen definitely improved her practical nursing skills and her theoretical knowledge during the summer, I think that she left Colorado feeling, somewhere within herself, that she had failed there. She had loved her first year of nursing school and had been a very good student, and she returned for her second year convinced that she was much better suited to hospital nursing. Her initiative was obviously severely limited by her subservience, and she must have been more comfortable with the detailed instructions she was used to receiving in nursing school. This was not an idea which Eileen herself verbalized. She did tell me once, however, that she was very glad to have had a female medical student on her team, not a man, because she thought she would not have been as comfortable or learned as much with a man. I think that she must have vaguely understood her need to be especially subservient to men and the way in which this need kept her from growing into greater independence.

In her mind, I think, Eileen's feelings of failure had to do with her inability to be at ease with patients. She must have felt that patients did not like her as much as they liked Karen, Sandy, or me, and indeed patients did not respond as warmly to her because of her own lack of warmth. She was especially afraid of children and often frightened them in turn with her abruptness. In her heart she loved them and felt very tender toward them, but she was rarely comfortable enough with them to smooth out her physical

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examinations with the affectionate touching that relaxes many small children. During our second month of work Eileen spoke several times of her feeling that she was "not good with people" and said that she was thinking of working in research after nursing school.

If Karen and I had spent ordinary eight-hour work days with Eileen, perhaps we would not have threatened her so. As it was, we were all dependent on each other for comradeship for two months, and we revealed ourselves and examined each other in ways we might not have if we had not lived together. As it was, I wonder if we threatened Eileen most dangerously about her relationship to her parents--something we most likely would not have come to know so intimately in Eileen in an ordinary working situation--for, as the summer wore on, her increased nervousness in doing health care tasks developed alongside certain changes in our talks about our closest relationships. As Eileen laughed off her father's criticism, Karen and I were disturbed by the enormous anger which she must have needed to push beneath her coping defense. Eileen had become the clumsy, inadequate child-woman of her father's needs, an ugly duckling. She fulfilled his criticisms, and that made him right and her wrong. Since he was right, she was right in directing any anger she had over this outcome at herself, not at him.

Karen and I began to question Eileen directly about her one-dimensional love for her father. "Aren't you ever angry that he knocks you so?" we asked, perhaps too often.

And usually she said that she was not, that it was just his way. He did it to her mother and sister, too, so she knew it was just his way of showing his love. Then there was a short time, maybe a week, during which Eileen admitted twice to me that she did feel a little angry at him sometimes for being so critical. But she soon drew her nervous laugh over the wound again to laugh him off. Had we poked too viciously at her defense, out of our own anger and pain--the anger and pain of having depreciated ourselves in the past, as adolescents and as women, and of often tumbling into it unawares, out of habit, now and probably forever? Or did Eileen change her mind because her parents were planning to visit her in Greeley, because her father loved what he had made of her and would not love what she could make of herself? She became more obsequious, more self-deprecatory, more aggravating. It was a relief to get away from her.

For the rest of the summer I got away from Eileen when I could. Perhaps I should have exploded instead when she taxed my patience, but I felt that she had put me in a bind. I could not talk to her about the most important source of her nervousness because she had closed off that line of thinking herself, and it was hard for me to talk to her about her work. She looked to me for criticism, and I was in the position of sometimes having to give it. But by the middle of the summer I no longer felt that Eileen could use suggestions constructively. Although she was very eager

to learn and insisted that she wanted my criticism, without hesitation, I did hesitate. If she was having trouble with a part of the physical examination and I taught her to do it properly, she seemed stunned with pain. She would react by downgrading her work profusely, and her facial muscles would tense into the first quavering movements of a person who is eventually going to cry. It was as if she went through life taking blow after blow, inviting others by her own exaggerated inadequacies to mete them out, and yet hoping beyond hope that the antagonist in each brief incident would love her in her inadequacy, would accept her just as she was and find nothing at all to criticize in her. Anyone who could not be her much-needed magical man of all-forgiveness--and therefore everyone--was, to Eileen, an all-hater. I did not like being made into such a powerful and hostile figure in her mind, and so, when I was forced to make suggestions to Eileen about her work, I hated her for the moment. I hated her for hating me--and, as the powerful and hostile figure she made me into in those moments of confrontation and terror, she surely must have hated me.

Perhaps I goaded her into expressing some anger toward me. On the day before I left Greeley, she finally raised her voice at me to tell me that I had hurt her. I had asked Karen and Sandy to fill out my follow-up cards, but I had not asked Eileen. I had struggled for several days over what to do about the cards for the LaSalle children. Eileen would be at that school, but I really did not want

her to fill out the cards by herself. She had had only one year of training, and her assessment of clinical problems was naturally not yet very accurate; furthermore, she could be very disorganized at unfamiliar tasks. I was afraid that her follow-up notes would not make sense to me two months later, and at that point in late July I had a strong emotional investment in eventually making some sense of my work experience through my cards. I knew that Eileen would be hurt, even if I discussed my decision with her in terms of her real inexperience. But I also vaguely understood that I wanted to hurt her, out of my own anger at both her subtle hostility and her blatant incompetence, and, perhaps because I was ashamed of my cruelty, I said nothing to her. When Eileen herself brought it up, I realized that I had acted wrongly toward her by not being honest, and I apologized and discussed the problem more openly with her. But Eileen immediately apologized, too, for having appeared angry. This was an anger I was not uncomfortable with, for I had deserved it, but when I insisted that Eileen had a right to be angry with me and that anger is a natural part of hurt, she again assured me that, although she had been hurt, she had not actually been angry.

When Arnie and I started our long drive west, I spent many quiet hours in the car passing the memories of the summer through my mind again. By the end of our first day of travel I was struck by how little thought I had given Eileen. In Greeley I had often felt obsessed with her. In

my mind I was constantly going over all her little inadequacies and feeling angry with her for each one. In talking with each other Karen, Sandy, and I obsessed together over Eileen--with more laughter, it is true, than I mustered by myself, but I wonder how much of our laughter was really derision. I suppose that in some ways Eileen was a team scapegoat--I know that there was a part of me that detested her incompetence--and although she set herself up for it, I wonder if we in turn sometimes used her cruelly. I can only reexamine my own part in it, but an ill-defined shame that accompanies my every memory of Eileen makes me think that I for one obsessed over her incompetence to feel ever so competent in comparison. I would guess that scapegoating is as common a problem on health teams as in any group of human beings. I hope that I learned enough about myself this summer to resist its temptations next time.

Chapter 4

BURLINGTON

One Sunday in June Arnie and I drove south for three hours from Sterling to Burlington, a small town near the Kansas border. The Student Health Program team there had planned the first migrant clinic of the summer for that day, and they expected many more patients than they themselves could see. The only building available for the clinic was a grammar school. When we arrived, many families were waiting outside to register. As we entered, in one room we saw many more people waiting to tell their health problems to the nurses, in another to have their teeth checked by a dental student, and in the hallway to see a doctor. The "doctors" were one Family Practice resident (who had come out from Denver for the day) and three students. Each student had had three years of medical schooling but very little experience in outpatient problems.

I was given a kindergarten room for an office. I set up an examining table which was not much higher than my knees and a consultation corner of tiny chairs. For the next eight hours I saw patients without a rest. Like the other students, I was confused by many of the problems I was seeing. We were all forced to waste some of our time in waiting for the resident to help us. For the first hour,

each time I stepped into the hall to call in another family, I saw again the crowd of patients filling the hall and felt a pang of desperation. I was overwhelmed. Gradually I resigned myself to constant frustration and said to myself each time I went into the hall: "No use feeling upset and helpless, you're going to keep working until all these people are gone."

I had never seen such a blatant need for health care. At the Greeley clinic I had already become accustomed to seeing patients with serious and neglected problems, or with long-lasting untreated conditions for which patients in New Haven would have consulted a doctor years before. One night a very sweet old man lifted his hands toward me to show me that they were gnarled from arthritis. He had watched his disease disfigure his hands for five years but was now seeing a doctor for the first time in his life. He had come only because his joints were finally aching beyond his point of tolerance. But at the clinic, whatever a patient's problem, we usually had the facilities for proper diagnosis and treatment. Besides, many of the farmworkers and settled-out people around Greeley had learned to use the clinic for well-child care and minor ailments. The migrants at Burlington had no real clinic, and our school-clinic was ridiculously inadequate for diagnosis and treatment. Many of them had serious conditions that had not previously been evaluated or treated. What we could offer at that clinic did not touch their need for competent and continuous care.

I feel moved by the enormity and outrageousness of the needs I saw to record that day in its medical details. I do not think that I can move others, and especially other health workers, by written words to step outside of their systems, their routines. Oh, I still have moments of hoping that my words will rouse concern in others, but my optimism and enthusiasm for social change have smoldered. My ideals are not different, but I am resigned to the slow pace of change which seems to characterize most civilizations and most minds. The Chinese and Cuban revolutions excite me now, as they did several years ago. But today I also know immersion in an American institution and its political struggles at many levels: professional versus professional and worker versus professional within the medical center, medical center versus community, medical center versus federal government, and more. Social change seems to me now to have a grinding quality that I did not previously perceive. It is as if the rotating gears of many machines interface; some teeth mesh and others bend out of shape, and from either motion, any motion, the structure changes form.⁴

Eight hours. Twenty-four patients. That makes twenty minutes per patient, and, as always, with each patient a great wondering arises within me. I want to know the intricacies of the mind that brings its body to me, the delights and pains, the eagerly told, the admitted, the hidden-from-me, the hidden-from-oneself. And with these people I want more. They are a culture strange to me. How

is it to stoop and harvest? My body does not understand their familiar movements. How is it to follow the crops? My mind is full of plans that have set like concrete. A month of work, if they're lucky, in Burlington, then there's nothing else for them there. Some tell me they are going soon to Ohio--or maybe to Michigan.

My mind wandered each time I waited for the resident. How is it to honor thy father and thy mother, to be a brother's keeper? My family has fragmented, it has exploded like a grenade, violently, at last, after all the arguments, after all the closed doors and the slammed doors. My family was anger and sorrow in many rooms. These are families of few rooms, and they enthrall me with their devotion, their gentleness with the old ones, their doting on the little ones--as if they could keep from them a little longer the meanness of their God-given lives. But I cannot romanticize: I have seen enough of their lives already to hate what it does to them. If they are devout, and devoted to each other, they pay for it with despair. Do I make out better? When I pass the heavy shingles of Fifth Avenue physicians, I remember that I too could amass a fortune.

But when the beauty of the stars on a clear night pierces through me, I know terror. And if the sky is too clear-black to keep the Milky Way away from me, it's so much the worse for me. How can space go on like that--infinity, astronomers call it--beyond the Milky Way, without a boundary? But if space were bounded out there, there would

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have to be something beyond, for there cannot be something, even something so close to nothing as space, and then, beyond, nothing. How could there have been nothing once, before the stars, before whatever came before the stars? But if there was something then, it must have come from something else. And if there was always something, where did it come from in the first place? How can something come from nothing? That's even harder than how nothing can come from something. Here is my mind at work, frantic in fact, existing, something, but doomed to be nothing. The further I get into space, the closer I get into me, the larger my secret terror grows. I want to imagine something I cannot understand, a force of a dimension I cannot even imagine. It must be there or there is no explanation for what I can imagine. But if I could imagine it--where did it come from? How could something come from nothing? What if I believed in God, like these people? What if I related some God directly to the events of my life, to my income, my marriage, the curse of a day of nausea and fever, the promise of every red-gold October leaf? What if I put God over me like a roof, instead of behind the Milky Way?

What if these people didn't wear God like hats? To be poverty-stricken, always moving, uncertain of next week's income; to look Mexican in every white Midwest town. Already I have seen the despair in many faces, in many bodies, the listlessness, the anger turned inward and left there to cripple and incapacitate. There is no proof that God-given

poverty feels any worse to them than the griefs and terrors I suffer in affluence. There is no outer evidence that a balanced diet, health care, a steady income, a sturdy home, increase the possibilities of getting through life with less inner pain. Yet I go on thinking my thoughts as if this were true. Trying to pull the strands of my own guilt out of my simple-minded politics would be suicide into a black hole of the mind. Guilt is my old friend, but now I'd like to begin somewhere else.

A couple in their thirties. The husband has severe and chronic conjunctivitis, and his vision is often blurred. His wife has had a mass growing in her underarm for six years. It looks a little grotesque, like an extra breast without a nipple, and it gets in the way of her arm movements when she works in the fields. If she wants it off, she's got to have surgery. She's afraid of an operation, so she promises to think about which is worse, an operation or a fleshy lump sagging further and further down her side.

Two thirteen-year-old boys, friends with each other, shy with me. One has been anemic; now his blood count is borderline acceptable. I send him down the hall to talk to the nutritionist about iron. The other boy seems healthy. Their parents obviously made them come in; if they want well-child care for their kids they'll have to grab it from medical students in schoolrooms.

A mother in her thirties, and three children. The

mother has a urinary tract infection. That's easy to fix, for now, with antibiotics. Maybe it will go away for good, maybe it won't. Her twelve-year-old daughter has complained of headaches for three years but has never had her vision tested. One of the nurses tests it and, sure enough, she needs glasses. That's easy to fix, too, if they can pay for them. The five-year-old daughter has chronic ear infections and fibrosed eardrums. She ought to be evaluated by a specialist regarding the eventual necessity of reconstructive surgery. That's in Denver, three hours away, but we can get her there and back if her parents are still working around here when we get an appointment. The seven-year-old son has a real problem: he has one bowel movement every few weeks, and always has. He has been hospitalized at various times in various places for high fevers, although his mother doesn't know of any diagnoses. She doesn't think he has ever had an X-ray study. Now he's having diarrhea around an impaction, so someone goes out for an enema bag and the resident and two nurses work on him most of the afternoon. Alternately they give him enemas and dig out bits of hard stool. Even in his moments of relief there is no place in the school to make him comfortable. He looks neither happier nor sadder than when he first sat on my table with his bloated load. He just hangs his little head and cries quietly for a minute now and then. Next week someone is going to have to think about diagnosis and long-term treatment.

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Another young mother with two girls. The seven-year-old has just had surgery in Texas for a congenital abnormality and chronic infection. The doctor in Texas is obviously terrific because the mother explains her child's problem to me as completely and correctly as the report which he has taken the trouble to send along for any doctor who might care for this child in her travels. She seems to be doing well now but needs a check at Urology Clinic in Denver to make sure. We can arrange an appointment by telephone. The mother wants to start taking birth control pills, but when I take her blood pressure it's too high. I tell her about the clinic that the health team has arranged for Friday, in the office of the one cooperative doctor in town. We can't do pelvic exams in schoolrooms. She asks me about losing weight and about preparing better salt-free meals for her husband, who had a stroke last year. She's fun to talk to because she knows she has a right to ask questions and get answers. She goes eagerly down the hall to ask the nutritionist more questions.

A middle-aged farmworker with diabetes and hypertension who is caught in the bureaucratic intricacies of having his prescriptions refilled by the Veteran's Administration in locations other than his home. Fortunately the resident knows how to fix things up because I don't.

One by one, four young women in various stages of pregnancy. One about half-way through has had a prior prenatal exam. Another is eight months along and has had

no prenatal care at all. The other two are no so far along but have had no prenatal checks yet, either. I tell them all about the Friday women's clinic, and they promise to return.

Various and sundry family groupings with colds, allergies, and other minor ailments.

A sixteen-year-old girl, alone, frightened. She has waited several hours to see me because she would not see one of the men. She has felt a lump in her breast; now I feel it too. I explain and reassure. I tell her I understand her embarrassment but to give her the best care I would like the resident to check it. She agrees and stays relaxed while he feels her breasts. We decide that the doctor in Burlington can do a needle biopsy during the week. Before she goes I try again to impress upon her the rarity of breast cancer in young women, while I think of a friend, a self-assured medical student, who discovered a lump in her breast one night as she was going to bed and lay awake until morning in dread.

Another girl, also alone, nineteen years old. She too has waited all day for "la doctorita", as someone out there has called me. Outside the sky is turning black, and all the nurses and medical students are building themselves huge sandwiches next door. I'm starved too, but I forget my hunger when we start to talk. Her name is Maria. She is supposed to be married next month when she goes back to Texas, but she has been having some vague pains in her chest

and wonders if there is something wrong with her heart. If anything is wrong, she tells me, she is not going to get married. I examine her heart and chest. I know she will be disappointed, but I must tell her that everything seems all right in there. She doesn't seem to mind, though.

Soon she is telling me about many other things she is worrying about. She has heard many things from other women and wonders if they are true: Doesn't sex hurt a lot? If you take birth control pills when you first get married, doesn't it make you unable to have babies later when you want them? She tells me that her fiance's parents made her visit a gynecologist to make sure that she was a virgin. She feels pressure from her own parents too to marry as a virgin--"the right way", she calls it--because her older sisters both eloped, after losing their virginity. Her father would like her to get married, the sooner the better, but she thinks she would like to finish high school. I smile to myself: a budding feminist with a male chauvinist pig for a father? Not a very helpful suggestion for Maria, who must settle her conflict within her culture, not mine. So instead I softly encourage her to listen to the whispers of her own desires.

She thinks a girl ought to be able to talk to her mother about women's things, but her mother has already betrayed her confidence beyond forgiveness. Her mother didn't tell her about menstruation before her first period, and that was wrong. Another time she didn't get her period

on time and told her mother. Her mother told her father, and that was really wrong.

Now she wants to tell me about something else. Her grandmother has died, only two months ago, and they were very close. Using her own people's standards, she offers me a measure of their closeness: at the funeral she vomited and had to be led away, sick with grief, from the grave. Now she longs for her grandmother.

Maria and I would like to go on. She wants to have more questions answered, more worries relieved, by my supposed wisdom. I want to hear more, for in her lyrical accent she has sung me a beautiful air of pain rocked within the tenderest of feelings. But we both recognize that, for us, there is no time for more. Her parents are impatient to drive home, and my friends want to close up the school at last. We say goodbye.

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Chapter 5

THE ROSALES

Strangely, my first patient at the clinic was to be my most important. When I speak of the exploitation of farmworkers or of their need for health care, it will always be this man and his family whose happiness I inwardly long for.

I could not have sensed that then. In fact, at first I found Mr. Rosales annoying. Since he was Mexican and did not speak much English, his wife, who was "Tex-Mex" (Texas-born), translated for us. Mrs. Rosales was a very short, overweight woman. Her face was pretty and, unlike many of the women who came to the clinic, she did not look much older than her actual years. But as she spoke I sensed her weariness. Her eyes met mine fully and expressively as she revealed her family's health problems to me, without shyness. But her voice was very quiet. It lacked animation, as did her body. It lacked energy.

The patient himself greeted me with a wide grin which revealed many missing teeth. Otherwise he was healthy-looking, with eyes that sparkled with his frequent grins. He was wearing neat work clothes and held a large cowboy-style hat on his lap.

The hat surprised me. Texas was a make-believe state

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to me, known to me only through television westerns I had seen as a child. Then, as we had driven out to Colorado, I had seen big, red-faced men in South Dakota and Wyoming wearing "cowboy hats", and we had many laughs over them before I convinced myself that real cowboys had preceded Western movies with actor cowboys, not vice versa (I had suffered a major setback a few days earlier when I ran into the Denver bus depot to use the telephone and happened upon three midgets in cowboy hats and boots, waiting, it seemed, for a bus to take them off to a circus-ranch where they would play at being cowboys.). Now I was surprised to see a Mexican man wearing a cowboy hat. But during the next few weeks I drove past many small groups of hoers in the beet fields and gradually accepted their protective hats as a real part of their own lives. In many ways Texas remained a make-believe state to me, but the Texas of my patients--its work and poverty, its lack of health care, its food and dress--became real to me. Still, during the entire summer, whenever I saw cowboy hats moving along slowly in the fields alongside the road, I always thought of Mr. Rosales and his hat, as if he had made that Texas life real for me by always being with me, ready to slide into my consciousness whenever I thought of farmworkers in an abstract way.

Mr. Rosales continued to grin his way through that first visit to my examining room. I understood enough of his words to find his humor charming, and yet he irritated me. He was flippant about his disease and did not want to

accept the seriousness of diabetes. He had had it for ten years; his urine glucose was high; his eyegrounds were absolutely a mess with hemorrhages and microaneurysms. I felt antagonism for this man who, despite these proofs of his illness, had not cared for himself properly. Mrs. Rosales added thoughts of her own as she translated her husband's answers to my questions. She told me that he had taken Diabinese at times but usually stopped when he felt better, and that he knew about diabetic diets but continued to eat sweets and drink beer. His diabetes had never before interrupted his work, but now he felt too weak to hoe beets, and his legs ached. He agreed to return to the clinic the next morning for a fasting blood sugar test and to see me again the next afternoon.

They were waiting in the back room when I came in the next day. Since Dr. Barra was nearly an hour late and I could not prescribe drugs without her, I was able to spend that time with them. I took a long medical history to find out what I really wanted to know: how they lived. A pattern emerged, and their hopes and despair. A doctor in Michigan had given him Diabinese once, a doctor in Ohio had given him Diabinese once, a doctor in Texas had given him injections for a month. No, there was no clinic like this at home in Texas, they had to pay so much to see a doctor there and they could not afford it. Yes, they understood that a diabetic always needs treatment, and they were thinking about settling out near Greeley so that Mr.

Rosales could get regular care at the clinic. Mr. Rosales continued to grin at me, although he occasionally looked thoughtful now. Mrs. Rosales was very worried, a little desperate, about his health.

I sent them out with another bottle of Diabinese. Dr. Barra would not consider insulin without trying oral medications first. I tried to imagine how a migrant would fit a daily injection into constant traveling, into the poor sanitary conditions of the dwellings they were given out in the fields. I hoped that the Rosales would settle out near the clinic, that Mr. Rosales would be seen regularly there and learn to use insulin. I hoped that he would feel well again. I gave them a Spanish pamphlet on diabetic diets and spent a few minutes going over food groups with Mrs. Rosales. I did not think that Mr. Rosales was about to change his eating habits, but at least I had done what I could.

Mr. Rosales came again to the clinic a few times in June, but by then I had started to work in the schools during the day and did not see him. I did meet his younger children at school, and late in June I met the rest of them one night at clinic. I saw from the family chart that both Mr. and Mrs. Rosales had come in a few days earlier with sore throats and had both had positive throat cultures. Meanwhile, the routine throat cultures we had done on their children at school had also revealed streptococcal infection in the family. Now Mrs. Rosales brought the children into the examining room in shifts. Except for Alicia, they all had

symptoms. I gave them Penicillin injections, from seventeen-year-old Robert down to three-year-old Anita. Like all children, they were fearful of the injections, but I was surprised that not one of them fussed. As each received the dread news, he or she would turn to Mrs. Rosales and begin to utter a protest. After seeing her stern brow and hearing her few words of warning, they accepted their fate quietly. But it seemed to me that they read from their mother's face not only the inevitability of the injection but the concern in her eyes for her children's well-being. I saw in their family, again and again, this concern, a tremendous feeling of responsibility for each other, mixed with tenderness. The concern was expressed, always, through their eyes, either in the way they looked intensely at each other or in the way they wrinkled the skin around their eyes if they were worrying about one family member's problem.

A few days later I went with Sister Catherine to visit the Rosales at home. Out there, away from the main road, the roads were laid out perpendicularly and named by number only. They were not roads that led to homes but roads that provided access to the many square miles of planted fields. After driving past many fields and few houses, we pulled into the dirt yard of a shabby little house.

Only Mrs. Rosales and Anita were home, resting in the late afternoon heat. We settled ourselves in the front room, Mrs. Rosales on one metal-framed single bed, I on the

other, and Sister Catherine on the only chair in the room. There was no other furniture, and the old wooden floor was dark and bare. What struck me was that, despite the shabbiness of everything in that room--the beds, the chair, the floor, the old wallpaper, the screen of the front door--whatever could be cleaned was very clean. I could not imagine within myself the determination it would take to keep so clean a shabby three-room home for eleven in a dusty yard. Mrs. Rosales had told me at the clinic that she was not working in the fields, but I saw now that she was nevertheless laboring very hard to provide a clean home, clean clothes, and meals for her husband and nine children.

I asked after Mr. Rosales, and Mrs. Rosales told me that he was feeling somewhat better. She and Sister Catherine also told me about Mr. Rosales' brother, who with his wife had come up from Texas with the Rosales to work the beets. He was a diabetic as well and was losing his eyesight, but thus far he had refused to come to the clinic for treatment.

Sister Catherine had bad news for Mrs. Rosales. She had been helping them with their plans to settle out and had just inquired that day about public housing in Greeley for them. But only eight people per unit were allowed in this low-cost project, and the Rosales were therefore automatically disqualified. We all knew that it was going to be very difficult for them to find a house large enough for them all and adequately heated for the winter, at a rent they could afford.

After a while Mr. Rosales came home with several children. I spoke with him again through Mrs. Rosales' translations and learned that, although he was feeling better, he felt very weak in the mornings. I thought that he probably needed a change in the timing of his medication and suggested that he return soon to the clinic. I asked whether he had tried at all to follow a diet, although I had not expected from his joking manner at the clinic that he would. To my surprise, he explained several changes he had made in order to follow the diet. He was drinking sugar-free soda instead of beer, and he was no longer eating sweets. The change in his attitude was just as surprising, for he did not joke with me at all this time. Just the opposite: he did not actually say that he was discouraged, but his voice and body said it for him as he spoke of his eagerness to feel well enough again to work, of his going to the fields in the morning to try to hoe beets but feeling too much weakness and leg pain to go on. My visit to his home, and my willingness to be a friend to his family, seemed to make a difference. Through the summer I saw him lively and humorous at times, but I never again saw the flippant front with which he had at first hidden his worries.

Now I learned that Mrs. Rosales was not feeling well either. She complained of waking up short of breath at night, of swelling in her hands and feet, and of fatigue. I told her that I would be glad to see her in clinic, where I could give her a complete physical examination, and she

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agreed to come in the next evening.

The problems of settling out were very complex and disheartening, and lack of money was at the heart of them all. Sister Catherine made plans with Mr. Rosales and Alicia to accompany them to the welfare office the next day to inquire about the possibility of welfare or disability benefits. Mr. Rosales had mechanical skills, and the Colorado Migrant Council could probably help him to learn English better and to obtain further training as a mechanic. But the uncertainty of his health was a terrible worry. He needed the clinic to regain his health, but if he settled out of the migrant stream to be near the clinic and he did not soon feel better, how would he support his family in Greeley? And I did not know how well he would feel, even if the clinic did as much as possible for him. I knew that he could feel much better if his diabetes were in better control, but his leg pains might represent diabetic neuropathy that would always incapacitate him to some degree, regardless of how well he followed the clinic's treatment plan.

In the meantime, the Rosales were worried about having enough to eat. The farmer for whom they were working had thus far refused to sign their application for food stamps, and they did not know where to turn. This was a common problem for migrants because farmers, afraid that their workers would leave before the job was done, often refused to give the needed signature until all their fields had been worked.

When Sister Catherine and I left after an hour of conversation, I had indeed become a friend of the family. The older children now took up their father's urging that I should come to the Fourth of July fireworks, as they were going and wanted to see me there. The two little girls hugged me as I left, and Anita was especially persistent in her affection (I soon learned why: although she was adorable and beloved, she was an incredible little chatterbox, and her own family was tired of her non-stop blabber. I, on the other hand, never interrupted her. Little Anita did not realize that I understood almost nothing of what she said--since she had not been to school yet, she spoke no English--but was happy just to hug her on my lap and delight in her animated face.).

As we drove back to Greeley, Sister Catherine and I talked about the Rosales. There was something special, even a little magical about them, and we all felt it: Karen, Sandy, Eileen, and Ricardo, as well as Sister Catherine and myself. Perhaps it was their tremendous desire for a better life, or the depth and complexity of their problems, or the warmth they offered to those who would meet their reaching out for assistance, that touched us. Sister Catherine told me how enterprising Mr. Rosales had been in his search for work when he had arrived in Greeley, and how important it was to him and his wife that their children be educated. They had proudly told Sister Catherine of the steady stream of A's their children brought home from school. Sister

Catherine was especially concerned about Alicia, who at sixteen had already taken on a great deal of responsibility for the entire family. It was she who accompanied her father to various offices as they tried to make plans for settling out. She not only translated for him but worried for him--for his health, for the family's financial predicament, for her mother's health as well. Of all the Rosales teenagers, Alicia alone let on that she had grasped the seriousness of her father's illness and its consequences, both emotional and financial, for the entire family. She had clearly been shaken by it, and when she spoke of her father there came into her face the same look of desperation I had seen on her mother's face.

Sister Catherine had helped Alicia to get a paying job as an aide in the Headstart group at the school, and Alicia was very happy there. She thought she would like to be a teacher, and Sister Catherine knew that she had the ability for it. But she also knew that children like Alicia, no matter how talented, need a great deal of encouragement and support if they are going to break out of the migrant stream to learn a profession.

The next night, at the clinic, I spoke at length with Mrs. Rosales about her symptoms and examined her carefully. Aside from being overweight and overworked, she seemed to be in adequate physical health. I told her that I thought she was awakening short of breath at night because she was very worried. After a while we got onto the subject

of her main worry, her husband's illness, and I gave her a Spanish pamphlet on diabetes that Eileen had found. She asked me a few questions about diabetes and I answered them. There was nothing more I could do for her as a doctor. What I could do for her as a friend was harder. I told her that it was only natural for her to worry so much. As she herself had said, her problems were very difficult to solve. It hurt me to have to agree with her, but what she had said was true. It was true, and I could not help her by denying it, by telling her not to worry.

There was something in her overwhelming problems that made it even harder for me to accept her desperation. I had been honest with patients before about disease and death, but her problem was different. Eventually it would be disease and death, too, but right now it was poverty. It was one thing to help a patient accept the sorrow of progressive disease or death, but how could I help anyone accept the frustrations of poverty? It was not inevitable, and it certainly was not fair.

A few days later the Catholic Church in Greeley held a fiesta for the migrant farmworkers in the area. First we attended a "Mariachi mass", with electric guitars and trumpets and everyone singing along in Spanish, and then, downstairs, we ate chicken mole, refried beans, and tortillas. After dinner the Mariachi band reassembled, and the dancing began.

While I was waiting in line for my dinner, I wondered

where the Rosales could be. They had assured me that they would be coming, and I was disappointed that they had not. Soon Sister Catherine came over to tell us that the Rosales had received news that morning of the sudden death of another of Mr. Rosales' brothers, just a few years older than he and also a diabetic. They would not be driving to Texas for the funeral because they did not have enough money for the trip. They had come to the mass but, too grieved to enjoy themselves at the fiesta, they had gone home.

The next afternoon I saw Sister Catherine at one of the schools, just after she had been to the welfare office with Mr. Rosales and Alicia. The welfare worker had not been encouraging about his chances for receiving disability benefits, but she had given him a form to be filled out by a physician. That evening, as expected, Mr. Rosales brought his form to the clinic, but Dr. Barra told me to ask Mr. Rosales to return the next night to see Dr. Bowen, who worked in the clinic one night a week. When I asked why, Dr. Barra explained that, because of funding technicalities, the clinic would receive fifteen dollars from the welfare office if Dr. Bowen filled out the form, but if the regular clinic staff performed this service, no reimbursement would be paid. I felt too stupid, too guilty, perhaps, to tell Mr. Rosales the truth. There was something insulting about telling a farmworker to drive another thirty miles the next night and wait another few hours because a farmworkers' clinic needs every dollar it can get. Instead I told him

that it would be better to have a male physician examine him. I knew that, for a complete examination, he would in fact be more comfortable with a man, but I nevertheless felt uncomfortable over my dishonesty in hiding my real, and angry, opinion of the supremacy of red tape to his inconvenience.

Mr. Rosales sat for a little while longer in my room. Although we spoke only briefly of his brother's death, he had clearly been shocked by it and thrown into depression and fear over his own diabetes. His body slumped on his chair, and he was having difficulty putting phrases together into sentences. He was feeling better in the mornings now, but he complained about pains and itching. I had never before heard him speak so vaguely about his own body.

The next evening Karen and I drove out to the Rosales' house to pick up the three oldest girls. They directed us to two more little houses--both miles away, down dirt roads, and extremely isolated--where some girlfriends lived temporarily with their migrant families. Then I dropped everyone at Sister Catherine's for an evening of singing. I had a few errands to run, and my first stop was the clinic. Mr. Rosales, waiting there again for his examination, seemed somber but less terrified now as he greeted me with a handshake and a few words. Robert had driven into Greeley with his father but now, wanting to join the other teenagers at Sister Catherine's, he asked me if I could give him a lift. In his asking me so comfortably for

a favor, I was struck by how much more a friend I was to him than a doctor.

As we drove out again into the dark fields that night, the teenagers, exhilarated by their singing, kept us all laughing by quizzing us on our Spanish vocabulary and making word plays out of our mistakes. But Alicia once again was the one who could not hide her sadness. The fun that Sister Catherine had organized provoked, for her, the loneliness of being without Sister Catherine, who would soon be returning to her regular assignment in Idaho. She asked us:

"Who are we going to have left here when all you people go?"

Karen and I assured her that she and her family would make many more friends in Greeley.

"Maybe, but not as nice as you," she replied.

About two weeks later, Karen and I brought to the Rosales two bags of groceries which Sister Catherine had bought for them but had not had time to deliver herself before leaving Greeley. When we went into the house, we accidentally awakened nine-year-old Daniel. He had not gone to school that day but had worked with the older children in the pickle fields and had fallen asleep, his mother told us, as soon as he had come home.

This time we sat at the kitchen table and talked while Mrs. Rosales unpacked the groceries. When she found a five-dollar bill in one of the bags, she quickly showed it

to her husband and tucked it away as she said something to him, just as quickly, that I could not translate. They were continuing with their plans to settle out, even though they had not yet found a house to rent. Mr. Rosales was feeling better, and a woman at the Colorado Migrant Council office had promised him training in English and mechanics and, after that, a job. Alicia again weaved her fears of loneliness and helplessness into her family's talk of their plans.

"I don't think God likes us very much now," she said. "He gives us friends who go away again."

We all agreed that it would be sad to part from our friends.

A few days later, Mr. Rosales brought Anita into the clinic. She was a sad sight, for one eyelid was tremendously swollen, and she had been crying with pain. But it seemed to be no more than an unfortunately aimed insect bite, and Anita was recovering already. Mr. Rosales spent a long time that evening with a nutritionist from our Student Health Program; she told us later that he had been very interested not only in his own diabetic diet but in better nutrition for his children. Since there were few patients at the clinic that night, we had time to chat with Mr. Rosales and Robert, Alicia, and Maria. We had already noticed, and happily, that they had been lingering at the clinic after their appointments to socialize with some of the permanent Mexican-American health workers. Now they had brought us grocery bags filled with the cucumbers they

had been picking. I promised to bring them a sample of the salad I was planning to make from their gift, and Mr. Rosales replied that he hoped very much that we could visit him and his family some time when we could all relax and eat something special together.

That relaxed visit never came about, for I was leaving Greeley soon. On my last Sunday there, Arnie and I drove out to their house with the cucumber salad. Mrs. Rosales had taken most of the children with her to the laundromat, and the house was quiet. Arnie's Spanish was fluent, and he and Mr. Rosales had a long talk, from which I was able to piece together a "Catch-22" sort of tale. Mr. Rosales wanted to become a United States citizen, and in Texas he had taken an English course that was supposed to prepare him for the citizenship test. But the course had not taught him about this country's laws, and therefore he had failed the test. Then he found out that, in order to take the course which covered this country's laws, one had to be a citizen already.

There were other catches in his present efforts to change his life for the better. He talked of his life as a farmworker and of wanting to leave it. He told us how hard the work was, how tired his children became from stooping in the pickle fields, how little they were all paid for their labor. But he had still had no success in finding a house to live in. When the pickles were done, they were planning to drive down to Texas and then to Mexico, where Mr. Rosales'

father, incapacitated from a stroke, was slowly dying. Then they would return to Colorado in time for the children to start school. I wondered whether they would really come back, whether they might not change their minds once they got back to Texas, whether the security of their family and friends and house there would weigh heavily against returning to Colorado, where they had neither friends nor family nor house. Would the health care and job training for Mr. Rosales still look like a promise of security and happiness?

I had heard that, when the first snow falls in Colorado each year, many migrant families who had hoped to settle out crowd their children and belongings into their cars and return to the warmth of the Rio Grande Valley.

Chapter 6

THE HEALTH STATUS OF MIGRANT FARMWORKERS IN THE UNITED STATES

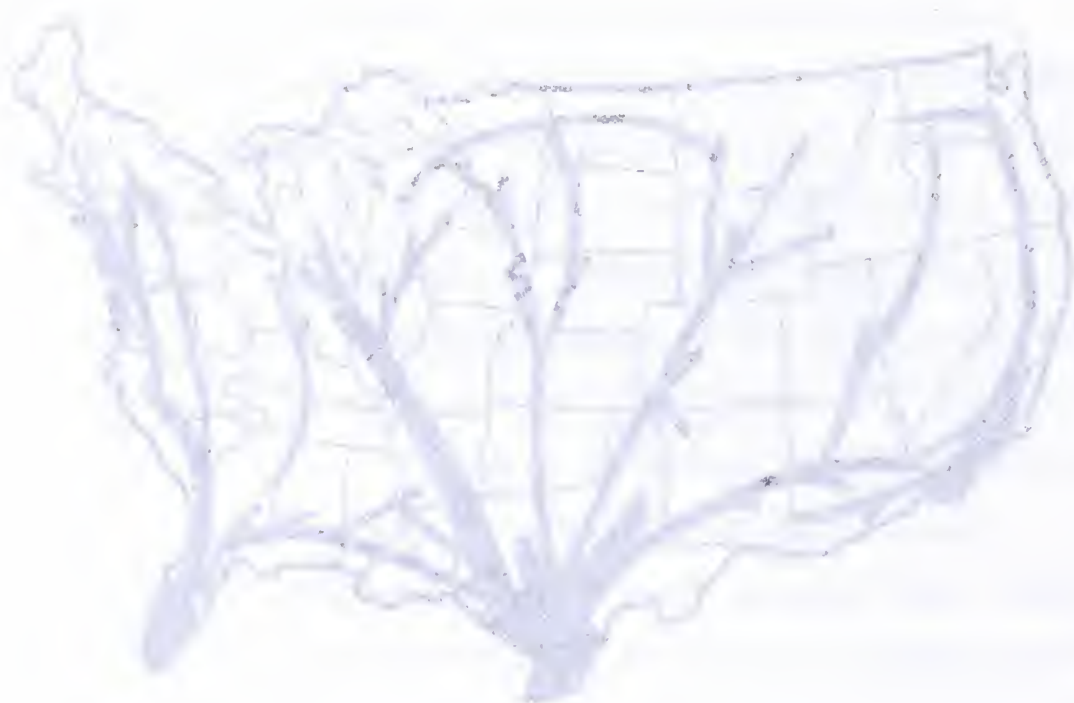
Here I leave my own narrow experience to present the health problems of migrant farmworkers throughout the United States. Most of the articles and books on migrant farmworkers are anecdotal, and many have concentrated on only one cultural group of migrants or one location in which migrants work. There is nevertheless one thread running through all this descriptive material: dismal poverty, and its ensuing lack of health and hope.

Three main migrant "streams" can be found in this country. The largest, that of my patients in Colorado, consists mostly of Mexicans and Mexican-Americans who travel up from the Rio Grande Valley into the Midwest in family groups. On the East Coast, the migrants are black, Puerto Rican, and Mexican-American. Many of them make southern Florida their home; there they work the winter crops, and then some travel all the way up the coast into New York State and New England during the summer and fall. In this stream, crews of mostly familially unrelated workers--organized, transported, and often terribly exploited by crew leaders--are common. On the West Coast, another stream of mostly Mexicans and Mexican-Americans travels up from southern



Figure 2

Travel Patterns of Migrant Farmworkers
(U.S. Department of Labor, 1961;
reproduced in Bowles, 1967)



(Continued)

Information relative to available funds
 (1) Amount of funds available
 (2) Source of funds

California through the fields of that state, and some go on to Oregon and Washington in the summer. Some Texas-based migrants join both coastal streams at times. There are some American Indians in the Midwestern and Western streams and some whites in all three.

Although their patterns of travel stand out boldly when marked thus on a map, migrants are, on the land itself, an unseen people. They find their work in the most rural, unpopulated areas of this country, and they find their temporary homes among fields that few Americans ever see. A handful of writers have ventured into the migrant's isolated world in order to reveal it to an American public which, unseeing, has taken its cheap produce for granted. In the past decade, several books have pointed out that the conditions of that isolated life have not changed since John Steinbeck first exposed them in 1939 in The Grapes of Wrath. Allen has written in The Ground is Our Table (1966):

Years ago manufacturers paid shamefully low wages to exploited workers in cruel sweatshops. But this lasted only until the spotlight of public attention was focused on the situation . . .

Why was the farmworker overlooked? Perhaps because he was invisible . . . the citizen of today cannot see . . . what goes on across the nation in out-of-the-way rural areas. Here are the blue-sky sweatshops.

Moore has painted the details of this isolated existence in The Slaves We Rent (1965). Like Allen, he has put its stagnancy into the proper context, the growth of agribusiness. Farmworkers, needed for shorter and shorter peak periods of harvesting, have become creatures that are easily dis-

carded for the remaining eleven months of the year, out of sight and out of mind of their corporate employers. In The Rights of the Poor (1974) Law has outlined the almost total lack of rights which the migrant has endured as agribusiness prospered, all the while that social legislation has greatly increased the living standards of industrial workers.

Taylor has investigated the plight of farmworker children who, in their isolation, are not protected by governmental agencies from child labor and its hazards (Sweatshops in the Sun, 1973). Nelkin has documented other illegal forms of exploitation which most crew leaders are able to practice precisely because of their workers' isolation, even from food stores in many cases (On the Season, 1970). In Migrants, Sharecroppers, Mountaineers (1971) Coles has recorded the words of Southern migrants and shown how their total exclusion from the mainstream of American life results in the psychological reactions of a people without hope.

At this time of crisis in our health care system, when two major issues are the lack of health manpower and facilities in rural areas and the soaring costs of medical care, it comes as no surprise that migrant farmworkers, in their extreme isolation and poverty, receive very little health care at all. They often cannot find it, and they usually cannot pay for it. And the unsanitary and hazardous conditions of their work and homes make them more susceptible

to illness and injury than most Americans. The result has been an extremely poor health status, striking not only to me in Colorado but to a number of other health workers who have cared for migrants in other places.

Statistical data on the health problems of migrant farmworkers is scant, probably in part because of the general inattention of Americans, including doctors, to farmworkers. But even those health workers who have seen migrants as patients have not often produced scientific studies. At this point in time, there is something irrelevant about analyzing patterns of illness among migrants. Their illnesses are those that have been under control or absent in the general population for two or three decades (I do not mean to deny the importance of clinical research; on the contrary, more careful research on the health of migrants could make easier the difficult problem of providing care for them.). Confronted with the overwhelming health needs and unnecessary ailments of migrant patients, health workers seem to have preferred to use their energies for these immediate problems and to have let their shock speak more eloquently than statistical data ever could. Drs. Raymond Wheeler and Harry Lipscomb, members of the Citizens' Board of Inquiry into Hunger in the United States, reported to the Senate Subcommittee on Migratory Labor that they had travelled to Hidalgo County, Texas (home base of 37,000 migrant farmworkers) to study 50 migrant families and report on their health status.

Our team went down to see 50 families, and there were 900 people waiting in the street the day we got there. We were swamped. We worked day and night for five days. We went to study the families in depth, but the first child you saw with tape worms, hook worms, pin worms or with active ear infections or a pulmonary lesion, you were compelled--you had some visceral compulsion that made you have to treat these people. You couldn't turn them away . . . They all needed treatment (Migrant and Seasonal Farmworker Powerlessness, 1969).

Efforts at the national level have been important in the first steps toward health care for migrants, and the next steps will certainly be directed, in part, by changes which seem imminent in the entire American health care system. Although there are some differences in the health problems of migrants in different locations within this country, their most important health problems stem from the economic exploitation and resultant poverty which they all share.

The migrant and farmworker population. Reported figures of the number of migrant farmworkers in the United States vary greatly. Geographic movement itself, plus the tendency for many migrants to work part-time at other jobs or settle out in one location, make it difficult to determine at any one time how many farmworkers are true migrants and how many are seasonal agricultural workers living in one location. Furthermore, a large but undetermined number of Mexicans work illegally on United States farms. In 1970, for example, the Comptroller General (1973) reported that 56,203 aliens were found working illegally in agriculture. Many more, of course, were not found. This same report gave

the following estimate:

	<u>1960</u>	<u>1970</u>	<u>1975</u>
All farmworkers	3.69 million	2,49 million	2.10 million
Migrant farmworkers	409,000	196,000	100,000

The chief officials of the Migrant Health Branch of the Public Health Service, however, estimated more than one million migrants in 1965 (Johnston, 1965), and Law (1974) more recently gave a figure of 750,000.

The decreasing number of farmworkers, as shown by the above figures, reflects the increasing mechanization of agriculture. But attempts to mechanize the harvesting of many fruits and vegetables have been unsuccessful, and human harvesters will remain a sizable group for many years to come. Although the true number of migrant and seasonal farmworkers is important for planning their health care, the health status of these two interchangeable groups does not now differ greatly, and they are often lumped together. In fact, both groups are so needy that the Migrant Health Act has recently been revised in order to provide more health facilities for farmworkers who are not migratory but, because of the nature of farmwork, are only seasonally employed.

Dr. Ramiro Casso of Hidalgo County has pointed out:

" . . . the migrant may be better off than the farm worker who stays the year round in the Rio Grande Valley because by migrating the worker becomes part of a readily identifiable group and can receive emergency federal aid. Those who remain in one area and work are invisible to most, if not all, governmental functions and services. They suffer the same malnutrition and medical problems." (Taylor, 1973)

The migrant population is young. The Comptroller General's report estimated that, in 1970, 800,000 children under the age of 17 did farm work (Not all were migrant and seasonal farmworkers' children.). This same report estimated that 38% of migrant farmworkers are between the ages of 14 and 17. A Department of Agriculture report (Domestic and Migratory Farmworkers, 1967) gave this figure as 25%, with an additional estimate of 50% under the age of 25. Frank (1972) has stated that 63% of the migrant population (not workers alone) are 16 years of age or younger. This very large population of minors suffers frequent accidental injuries incurred in illegal farmwork, as well as economic exploitation, interrupted education, and social deprivation.

Income. Again, these figures vary, but all reports cite very substandard incomes for migrant farmworkers. A 1970 OEO study of 4,000 migrant families gave the average income for this group as \$2,021 per family, the average size of which was 6.4 members; the OEO's estimated poverty level that year was \$4,800 for a family of 6 (Comptroller General, 1973). Department of Labor figures for the same year were higher than OEO's: \$1,697 per worker (including children). The average earnings per day were \$13.80, and the average number of days worked was only 123 (Frank, 1972). In 1972, while the average American family of four was earning \$9,800 per year, the migrant farmworker family of four earned \$1,800 and needed 2.3 workers per family to

reach that level (Barnett, 1972). Of all occupational groups in the United States, the migrant farmworker has the lowest annual income (Nelkin, 1970); furthermore, the economic position of farmworkers relative to wage workers in other industries has actually deteriorated since World War II (Bowles, 1967).

Education. The Department of Labor (1967) has estimated that the adult migrant farmworker "completes" an average of 8.5 years of schooling. This must be considered within the context of infrequent school attendance because of migration and child labor and, for the many Spanish-speaking migrants, the absence of bilingual school programs.

Housing and sanitation. Overcrowding and poor sanitation lead to an increased incidence of infectious disease among migrants. The Comptroller General's office studied six geographic areas with large migrant populations and found a shortage of safe, sanitary, low-cost migrant housing in every area. In addition, very little housing was currently being constructed. In Hidalgo County, Texas, only 13 out of 48 farmworker families interviewed had indoor plumbing, and only 9 had indoor toilets. Another study found 57% of 90 migrant families in Hidalgo County without hot water in their homes, 35% without an indoor water supply, and 10% without any water supply at all on their own property. 52% were without indoor toilets (Chase, 1973).

Fuentes (1974) has written of California farmworkers:

. . . most of the housing facilities in existence were originally designed for "braceros" who were either single men or men who came without their families. Therefore, very few labor camps have housing to accomodate even 40 per cent of the migrant workers that come to work the crops each season. In many places during the crop season the migrant workers live in circumstances which the word "substandard" is too fine a word to describe . . . we often find families of five to nine living in a small trailer with not even standing room left when all of them are in bed . . . we helped a family of nine that for 2 years in a row spent the 3-1/2 months of the crop season in a Ford station wagon . . .

Barns, substandard housing, and some rough shacks built in the marginal areas of the ranches form most of the dwellings of these groups. Without adequate bathroom and sanitary facilities it is only natural that these areas become breeding places for the diseases that the migrants will carry to the next county or state.

Coles (1965) has described the "rat-infested, one-room hovels with improper sanitation" that shelter many migrant families in the East Coast stream. In 1973 a group of national legislators held a special hearing at a Homestead, Florida labor camp where typhoid fever had broken out (Environmental Healthfulness for Migrant Workers, 1973). County physicians testified that they were accustomed to seeing four or five cases of typhoid fever each year. At the time of the hearing, 133 people from the labor camp had already been hospitalized, and more were falling ill each day. County health officials had recently tested the labor camp's water supply, had found it contaminated with fecal bacteria, and had required the Homestead Housing Authority to correct the deficiencies. This had not yet been done.

Osband (1972) inspected 115 labor camps in one upstate New York county. The average dwelling had 50% of

its surfaces covered with lead-based paint, with 40% of the total paint peeling or chipping. Children were often observed to be unsupervised in camp dwellings, and pica was also observed.

In its 1974 report on the Health Services Act, the House Interstate and Foreign Commerce Committee stated that the only available data on migrant housing are anecdotal. The Health Services Act therefore required the Secretary of HEW to conduct a systematic study of the housing of migrant farmworkers, the effects of such housing upon the workers' health, and governmental standards for such housing. But it is doubtful whether clarification of these standards without rigorous enforcement procedures can lead to better housing for migrants. Much of the Homestead hearing was devoted to an intellectual search for the party responsible for this medical catastrophe. Local health officials repeatedly emphasized their frustrations in the face of the county's unwillingness to enforce existing housing and sanitation codes for migrant labor camps. Furthermore, many migrants' accommodations are never inspected at all ("Health of the Migrant Farm Worker," 1971). Only camps for 15 or more persons are inspected for labor camp permits; privately owned, single-family houses are not required by law to be inspected. Law (1974) notes that, throughout the country, local health officials have been "notoriously lax" in enforcing even minimal housing codes. In an article on migrant labor camps in Washington (1962), Smart pointed out

that Washington's housing code was less strict than federal recommendations but that the camps were usually so remote from regulatory agencies that even state standards were not enforced.

Occupational health. Farmworkers suffer from the same lack of enforcement of health codes in the fields as in their homes. Large-scale agriculture has for many years been the only industry not required by law to maintain standards of sanitation at work locations (Shafer, 1961). At the Homestead hearing, local health officials told of their long struggle to force growers to provide portable field toilets for workers. Finally they filed a law suit; it was thrown out of court. Despite codes to the contrary, in many states farmworkers must urinate and defecate in the open fields (Matthiessen, 1973). In addition to the lack of dignity which the workers experience, they expose themselves and consumers to the dangers of contamination.

Accident rates for farmworkers are estimated to be three times as high as for the general population (Fuentes, 1974), and farm work is second only to construction in the annual number of job-related deaths (Comptroller General, 1973). Because most states do not offer workmen's compensation for farm employment accidents, the figures on farm accidents are not complete; but National Safety Council statistics showed 2,400 accidental deaths and 200,000 disabling injuries on American farms during 1970 (Taylor,

1973). Farmworkers also suffer frequent injuries in the unsafe vehicles in which they are often transported. As in other aspects of farm work, there is little enforcement (Shafer, 1961; Matthiessen, 1973).

Two special occupational health problems of farmworkers are accidental injuries to children and illnesses caused by pesticide exposure. There are many anecdotal reports of horrible injuries and deaths of children who were illegally employed to operate farm machinery. In California alone, over 500 workers under the age of 18 are seriously injured each year (Moore, 1965). Taylor (1973) reported a 13-state study of 789 fatal tractor accidents; 12% of the victims were between the ages of 5 and 14, too young to be legally driving or even working around farm machinery.

Deaths due to pesticides have been reported anecdotally for children and adults, but accurate figures are not available. In 1970, the Senate Committee on Labor and Public Welfare estimated 800 deaths and 800,000 injuries each year from pesticides (Comptroller General, 1973). California is one of the few states to have worker-protection regulations for pesticides, but 1,400 pesticide poisoning cases and 9 or 10 deaths are nevertheless recorded each year on that state's farms. 85% of the pesticide deaths there have been in children under 16 (Taylor, 1973). In a study done by the California Department of Public Health, 20% of a large farmworker sample had five or more of the symptoms

of cholinesterase depression from pesticide exposure (Taylor, 1973), and in Hidalgo County, Drs. Lipscomb and Wheeler found evidence in many migrant patients' medical histories for both acute pesticide poisoning and cholinesterase depression (Migrant and Seasonal Farmworker Powerlessness, 1969).

Nutrition. Taylor (1973) asked Dr. Casso of Hidalgo County what his patients' "Number One" medical problem was. Dr. Casso replied:

"Malnutrition. Protein malnutrition. It affects almost everybody. It shows up as anemias, nutritional anemias, the wasting of muscles, poor resistance to infections, increased incidents of a lot of things you and I don't have in our children, such as draining ears, upper respiratory infections, a lot of skin infections, diarrheas.

If we could feed these people the protein they need, the medical problems would virtually be eliminated."

Drs. Wheeler and Lipscomb also reported that they found malnutrition, and primarily protein malnutrition, to be a major problem in Hidalgo County (Migrant and Seasonal Farmworker Powerlessness, 1969). In addition, they saw cases there of aribinoflavosis, rickets, and pellegra. They testified:

. . . The children we saw that day have no future in our society. Malnutrition since birth has already impaired them physically, mentally, and emotionally. They do not have the capacity to engage in sustained physical or mental effort . . . which is necessary to succeed in school, learn a trade, or assume the full responsibilities of citizenship . . .

Larson (1974) and Chase (1971) have tried to define the nutritional deficiencies of the Texas migrant population in

order to improve their nutrition. Both found many children in their large samples to be below the third percentile for growth measurements; they believe that their data indicates a general nutritional deficiency among migrant children. Vitamin A deficiency was the most striking finding in both samples. In addition to seeing frequent clinical signs of Vitamin A deficiency, they actually measured serum Vitamin A levels and found that 28.2% (Larson) and 55.2% (Chase) had abnormally low levels. Chase also found a significant correlation between low serum Vitamin A levels and frequent skin and upper respiratory tract infections.

Fuentes (1974) reports that malnutrition is also the "Number One" medical problem of California's farmworkers. Eisner (1972) found anemia to be common in California migrant children. In a study of 150 farmworker children, almost all below 2 years of age, and half between 4 and 8 years, were anemic (Gilbert, 1972). A summer health project in Oregon found that 10% of the Mexican-American children visiting the clinic and 20% of the Caucasian children were below the third percentile for height (Duncan, 1971).

In a study of 35 predominantly black Florida migrant farmworker families, Delgado (1961) noted cases of rickets, marasmus, kwashiorkor, obesity, emaciation, and anemia. By assessing the dietary intakes of these families, he found that 26% of the families had a calcium intake lower than one half that recommended by the National Research Council; figures for Vitamins A and C were 42% and 66% respectively.

In another study of Florida farmworkers, Vitamin A deficiency was not a problem, but 25% of blacks and 12% of Spanish-Americans had hemoglobin values lower than the acceptable range, and 40% of blacks and 35% of Spanish-Americans had unacceptable red cell folate values (Kaufman, 1973). A 1971 article ("Health of the Migrant Farm Worker") has mentioned anemia and obesity as major problems in Florida farmworkers and listed many environmental factors which contribute to their dietary deficiencies: poor kitchen and storage facilities; inaccessibility of competitively priced food stores because of isolated location; undependable income; unavailability of commodity foods, food stamps, and community assistance; lack of transportation; fatigue; lack of home management skills; lack of education and motivation. Coles (1965) has pointed to an additional factor, which he believes contributes to vitamin deficiencies in people who, ironically, are surrounded by fresh fruits and vegetables:

. . . many stubbornly refuse to make changes in their diets. Ignorance is surely one part of the explanation, but our interviews suggest that another part is a strong aversion to eating what they must live by and work upon. In several cases we saw real revulsion at the mention of eating or serving a tomato or orange--a real kind of fear, as if in some way all the anger they felt at having to harvest those foods for a living would eventually come to haunt them and live in them if they were consumed.

As in every other aspect of migrant life, the ineffectiveness of governmental agencies and the wealthy economic interests controlling them are major factors in the ongoing poor nutritional status of migrant farmworkers.

Although a 1969 Supreme Court case established that migrants are eligible to receive food stamps and other welfare benefits in temporary residences (Law, 1974), many local welfare departments remain opposed to granting these rights. In 1971, Hidalgo County still had no food stamp program (Taylor, 1973). Needy migrants were forced to rely on government surplus commodities which, Dr. Casso said, were poor sources of protein. Many rural counties have been very resistant to instituting even food surplus programs, and some counties have cut food supplies off at the start of the harvest season so that farmworkers would be forced to accept low wages in order to survive (Taylor, 1973).

In another denial of federally legislated benefits to local farmworkers, Texas left unspent almost one-half of the 1969 Title I Migrant Amendment funds for children's food services, while refusing migrant parents the free lunches which these funds were supposed to supply for their children. Nationally, a million dollars budgeted for migrant school food services went unspent in 1970. The National Committee on Education of Migrant Children reported that year that the majority of migrant children were hungry most mornings and did not receive free lunches during the regular school year (cited by Taylor, 1973).

Marvin Levin, Food Program Specialist with the Child Nutrition Division of the Department of Agriculture, indicted his own agency at a 1972 Congressional hearing (Migrant Children's Nutrition, 1972). He testified that migrant

children were going hungry because of the USDA's bureaucratic inefficiency and "pervasive insensitivity". He outlined many ways in which the USDA had withheld funds allocated for migrant children's nutrition, thus causing other agencies, such as Title I educational programs, to divert their own funds in order to feed children. Taylor (1973) affirms that, throughout the 1960's, the USDA cooperated with county officials in not instituting federal food programs. People were allowed to go hungry, despite federal funds made available by Congress and an executive order to establish these programs. In 1969, two army officers who surveyed federal food programs in a number of counties across the country reported to a White House committee that they had seen "'zombies'" in household after household--children with energy to do no more than stare at the walls because they were not being fed. They testified that in some counties surplus food programs were operated only when no farm work was available, and in others local officials interpreted rules in such a way that those who were capable of work could receive no food (Taylor, 1973).

Inadequate health facilities. When Drs. Wheeler and Lipscomb examined farmworker families in Hidalgo County, they found that at least 90% of the diseases they saw were treatable. But in Hidalgo County there are 4,000 people per doctor. Of the two adjacent counties, also heavily populated with farmworkers, Starr has 10,000 people per doctor, and Willacy has no county hospital (Migrant and Seasonal Farm-

worker Powerlessness, 1969). Dr. Casso told Taylor that, even where health facilities existed, they were usually inaccessible to the poor farmworker: "'The people are too proud to come in and beg, and they have a pretty good idea they are going to be turned down anyway.'" Drs. Wheeler and Lipscomb testified that certain hospitals in the Rio Grande Valley would not admit a farmworker without a deposit of \$150, and that some hospitals admitted emergency cases but used illegal practices to force indigent migrants to borrow money at high interest rates. In California as well, some conservative county governments intimidate the poor from using county hospital facilities by such means as forcing farmworkers seeking care to sign a lien against any property they own (Taylor, 1973). Residents of the Homestead labor camp testified that, when typhoid fever broke out in the camp, a local hospital persistently turned away very ill farmworkers (Environmental Healthfulness for Migrant Farmworkers, 1973).

In a study of 55 rural physicians in upstate New York, half the respondents felt that they could not deliver adequate care to migrants because of the demands of other patients, and some regarded the care of migrants as burdensome (Dean, 1971). Hostile or negative views toward their care was expressed more frequently by older physicians of rural origin. Barnett (1972) and others have emphasized that, even when rural physicians are not hostile toward migrants, they are already so overworked that they do not

want to participate in migrant care.

Of 35 California counties employing farmworkers in 1964, only 15 offered health services to indigent out-of-county residents, and only 9 offered such services to out-of-state workers (Gilbert, 1968). California's Farm Worker Health Service, one of the oldest and best migrant health projects in the country, reports that it only reaches 15% of the state's seasonal farmworkers because of underfunding, lack of manpower, and lack of physical facilities (Taylor, 1973).

Because of such inadequate facilities, and because of suspicion and confusion over different health services available to them in different locations, migrants do not often see physicians. In a 1963 migrant health project, one-third of the patients seen that summer had never before seen a physician, whereas the total United States rural population averaged 3.8 physician visits per year (Johnston, 1965). Coles (1971) and a migrant mother have summed up the consequences:

. . . the hunger and the chronic malnutrition that they learn to accept as unavoidable; the diseases that one by one crop up as the first ten years of life go by, diseases that go undiagnosed and untreated, diseases of the skin and the muscles and the bones and the vital organs, vitamin- and mineral-deficiency diseases and untreated congenital diseases and infectious diseases and in the words of one migrant mother, "all the sicknesses that ever was." She goes on: "I believe our children get them, the sicknesses, and there isn't anything for us to do but pray, because I've never seen a doctor in my life, except once, when he delivered my oldest girl; the rest, they was just born, yes sir . . ."

Perinatal care. Maternal deaths are 30% higher, and infant deaths 20% higher, in the migrant population than the national average (Migrant and Seasonal Farmworker Powerlessness, 1969). In California, the perinatal mortality rate for Spanish-speaking farmworkers is 50% in excess of that for white professional and technical workers (Gilbert, 1972). A migrant health project studied 313 migrant women of childbearing age; 80% had had one or more fetal deaths, 60% had had no prenatal care, and 67% had delivered "at home"--for many, a labor camp (Johnston, 1965). A public health nurse who went into New Jersey migrant labor camps found that most of the pregnant women had not registered for prenatal care that was actually available in that location (Uhde, 1964). Chase and Larson (1973) found that only 52% of 200 Hidalgo County farmworker children had been born in a hospital. Of the 10 migrant families which Coles studied, the children were delivered by doctors in only 2 (Coles, 1965). Coles pointed out that, even if good obstetrical care had been available to the migrant mothers he met--and it was not--their fear and superstition would have to be overcome, and doctors and hospitals would have to make some accommodations to the cultural attitudes of migrant groups toward childbearing. He found that many migrant mothers are afraid to deliver their children in a hospital out of fear that their babies will be hurt there. Northcutt (1963) studied a large group of black migrant and nonmigrant farmworker women who delivered infants in Belle Glade, Florida,

a city with a high farmworker population and an active migrant health service. There almost all the women had entered a hospital for delivery, but neither group had received adequate prenatal care. Poor prenatal care in migrant women has generally been attributed to their mobility, but Northcutt believes that this simplistic theory can now be discarded because of the very similar low level of care found in both groups.

Infectious disease. Migrant farmworkers suffer from high rates of infectious disease. The migrant farmworker's life expectancy is 49 years, compared to the national life expectancy of 70 years (Migrant and Seasonal Farmworker Powerlessness, 1969); in the state of Washington, it has been reported to be even lower, 38 years (McConnell, 1971). Migrants' mortality from influenza and pneumonia is twice as high as the national average, and mortality from tuberculosis is $2\frac{1}{2}$ times as high (Migrant and Seasonal Farmworker Powerlessness, 1969).

A public health nurse has written of migrants who arrive in Wyoming in early spring:

 Their need to earn a livelihood and their hope that this year's weather will be better keeps them coming in spite of their inability to provide themselves with suitable clothing or travel money. Because of fatigue, inappropriate clothing, crowding, and nutritionally inadequate food, there is always an immediate seige of upper respiratory infections, intestinal upsets, and diarrhea on arrival at their destination . . . referred to as "shipping fever" by the county health officials . . .

Drs. Wheeler and Lipscomb reported seeing a great deal of

infectious disease, both viral and bacterial, in Hidalgo County, and parasitic diseases were "the rule" (Migrant and Seasonal Farmworker Powerlessness, 1969).

Health status of migrant children. In addition to nutritional and infectious diseases, Drs. Wheeler and Lipscomb reported seeing several serious congenital malformations, never treated, in farmworker children. Speech, hearing, and vision problems were common, as were poorly treated traumatic injuries. Eisner (1972) found serious and untreated conditions in California migrant children.

Gilbert (1968) studied 222 infant deaths due to diarrhea in California and found that, although farmworkers comprised only 3% of the state's population, over 20% of these deaths occurred in farmworker families. Nationwide, gastroenteritis is still the biggest killer among migrant infants and children, as it was for the general population a generation ago (Siegel, 1966; Migrant and Seasonal Farmworker Powerlessness, 1969). In the Puyallup Valley of Washington, there had been a few deaths each year from pneumonia and gastroenteritis among migrant infants and children. In the three years since a migrant clinic had been established, not one more such death had occurred ("Children of Noplace, U.S.A.", 1961).

The high infant mortality rate among Washington migrants--41% of deaths were in children under five years of age--led to an investigation of the problem (McConnell, 1971):

. . . we saw babies locked in family cars or put down under scant shade surrounded by flies and filth to stay the entire day. Bottles of milk soured in the hot sun, and children often got no liquids and very little food. Dehydration and diarrhea followed, and doctors told us that in these cases parents frequently waited so long before bringing a child in for treatment that quite often the child could not be saved.

As in Washington, reports in Pennsylvania of unsafe conditions for farmworker infants and children led to the establishment of day-care centers (Sheridan, 1967). Siegel (1966) has called day-care centers for migrant children "the most needed and most promising direction of help", and McConnell (1971) has written: "We have boxes of records recording the contribution of these centers in all measurable dimensions: improved health, nutrition, social and educational development." A recent study of six areas with large migrant populations concluded, however, that the number of children needing day-care services exceeded the capacity of existing centers and that many children were still being taken to the fields or left alone in labor camps (Comptroller General, 1973).

Another special need of migrant children is more active immunization programs. Of 65 children aged 2 to 12 in a Kansas day-care program, only 50% had received diphtheria-pertussis-tetanus or polio immunizations (Gilbert, 1963). Chase and Larson (1973) reported that, in their sample of 205 Hidalgo County children under the age of 7, 21% had had no DPT and 23% had had no polio immunizations. This lack of protection has recently proven to be a significant health problem, especially in the Rio Grande Valley,

where poorly controlled border crossing may account for much disease contact (Migrant and Seasonal Farmworker Powerlessness, 1969). Drs. Wheeler and Lipscomb reported that, in 1970, 14 cases of polio occurred in unprotected children in the Rio Grande Valley; 3 of these children died.

Health status of migrant adults. Lindsay and Johnston (1966), directors of the Migrant Health Service, stated that the incidence of venereal disease and tuberculosis is the same in the migrant population as in other low-income groups but that the incidence of diarrhea, respiratory infections, skin diseases, muscular aches and pains, and trauma are increased. A Delaware mobile unit found that 0.2% of over 4,000 adult migrants had active tuberculosis; this was a much higher rate than in local communities. In addition, 12% had blood serologies positive for syphilis; of these, 70% were active cases requiring treatment (Mires, 1961). A New Jersey summer health project found 29 cases of active tuberculosis through routine screening (Darrah, 1962). In another New Jersey study (Harkness, 1968), a sample of mostly Puerto Rican adult male farmworkers were given diagnostic tests. Only 1 case of tuberculosis and 4 of syphilis were uncovered, but 59 out of 110 had intestinal parasites, 36 out of 110 had anemia, 61 out of 225 had hypertension, and 20 out of 100 had decreased and uncorrected visual acuity. The migrant population in Florida has higher incidences than the resident population of diabetes, hyper-

tension, heart disease, and other chronic diseases ("Health of the Migrant Farm Worker", 1971). In Hidalgo County farmworkers, Drs. Wheeler and Lipscomb found a high incidence of diabetes, several cases of thyroid disease, and frequent traumatic injuries which had received inadequate treatment. Older farmworkers suffered commonly from degenerative diseases such as arteriosclerotic heart disease and osteoarthritis, as well as from actinic changes of the skin which were often associated with basal cell carcinomas (Migrant and Seasonal Farmworker Powerlessness, 1969). Coles (1965) found that migrants in their twenties were already old:

On the whole these children, at five or six, seem cheerful, spontaneous . . . relaxed, in spite of their frequent poor physical health and the comparatively hard life they and their parents must live . . .

However, bit by bit over time this initial stamina faces challenges and threats. Physical health deteriorates--the first sight of some of the teeth, squinting eyes, infected skin and bent backs of "young" migrants in their 20's confirms that fact . . .

Dental care. Migrant farmworkers receive almost no dental care. Indeed, a Virginia study (Shanholtz, 1969) concluded that, for its migrant sample, dental care was the greatest health need of all. Drs. Wheeler and Lipscomb reported that every one of the 1400 Hidalgo County farmworkers seen by their team had dental problems (Migrant and Seasonal Farmworker Powerlessness, 1969). A health project which examined 596 migrant farmworkers over the age of 14 found only 18 without any dental defects (Johnston, 1965). 29 of 38 migrant children in Kansas needed dental care (Gilbert, 1963); over 75% of 204 children in one California

labor camp needed extensive restorative dental treatment (Lind, 1969). Kaufman (1973) reported periodontal disease in one-third of Florida farmworker children below the age of 6 and in over three-fourths of older children. Almost all those over 45 years of age had more missing than decayed teeth, and "the striking finding was the rarity of filled teeth." In another study of Florida farmworker families, 84% had caries and 35% had missing teeth (Delgado, 1961).

Mental health status of migrant farmworkers. The psychiatric problems of migrant farmworkers have received little attention. Drs. Wheeler and Lipscomb reported that mental and emotional disorders were common, although difficult to assess, in the patients they saw in Hidalgo County. Coles alone has investigated psychological development within the special, and stressful, context of migrancy. By presenting many of his conversations with migrant children and their parents, he has let these people speak for themselves (1971). They see themselves as excluded, overworked, powerless, even living "'in Hell'", as one mother said. Coles believes that it is "utterly part of our nature to want roots, to need roots." The degradation which migrants suffer in their constant denial of roots contributes to the fatalism and submission which migrant children learn:

. . . one can only go here, do that, and most of all, submit to the rigors and demands and confusion and sadness of travel . . . all of which can amount to a rather inert and compliant and passive life.

The fate which these children learn to accept is, Coles

believes, "terrible almost beyond description." Nevertheless, many migrants show "extraordinary resilience" under the constant stress of their lives and "preserve, as well as lose, some of their psychological stability and human dignity." The ways in which migrants lose their stability and dignity are shaped by their fatalism and passivity, and also by poor physical health which causes anxiety, irritability, and moodiness (Coles, 1965). Coles presents a "psychopathology of migrant life": many migrants drink heavily "to dull their sense in the face of, or in the wake of, their long hours of harvesting"; they may become violent toward each other or with their accommodations; many suffer from "apathy, gloom and severe depressions"; they use denial, projection, suppression, conversion reactions and, especially, psychosomatic complaints which often have a real basis in chronic disease.

Nelkin (1970) has also shown how the psychological reactions of migrant farmworkers reflect their precarious economic condition and their social rejection. From the diaries of 16 college students who lived for a summer in migrant labor camps in New York State, she has drawn a pattern of life which is shaped by the unpredictability of weather, crops, availability of work, and whims of crew leaders:

. . . Migrant workers, seeing little predictable relationship between their actions and consequences, consider their problems insoluble. They adjust, not through attempts to cope with their environment in a rational, goal-oriented manner, but through modes of

behavior which, in themselves, make their situation more tolerable by providing relief or reducing tension.

The workers reacted to the capriciousness of their lives by concerning themselves with immediate gratification. Another way in which they tried to adapt was by submitting entirely to the crew-leader system; they accepted its exploitative consequences in return for its protective and risk-reducing benefits. Migrants tended to neglect their own hygiene and health, partly out of a fear of the white world and mistrust of doctors, but also partly, Nelkin believes, as a defiance of order. She found that migrants expected disorganization, tended to prefer it at work and home, and often strongly opposed small attempts at organization of work tasks.

The work of Coles and Nelkin is extremely important in measuring the human costs which migrant farmworkers have been forced to pay in our economic system. Perhaps so little attention has been paid to their psychological and social adaptations because they so precisely and glaringly reflect the inequity which lies at the heart of that system. If migrants tend to be passive and irrational, it is because they could not otherwise survive with their utter lack of power over the shapes of their own lives.

Chapter 7

ABOUT SOLUTIONS

The first Migrant Health Act, passed in 1962, provided funds for clinics for domestic migrant farmworkers. Since then, re-enactments and amendments have made additional funds and services available; but even by 1968 migrant health services were being provided for only 25% of migrants (Emeline, 1969). In its report on the Health Services Act of 1974 (which funded community health and mental health centers, family planning, and certain other public health services, as well as migrant health services), the House Interstate and Foreign Commerce Committee pointed out that the first migrant health services had relied heavily on health services already in existence in local communities. By 1974, approximately 100 projects had actually been developed under the Migrant Health Act (Report to the Congress, 1974). Although the Administration did not want to increase the budget for services covered by the Health Services Act, Congress subsequently voted an appropriation that doubled the 1974 funds for migrant services (Congressional Quarterly, Aug.-Sept. 1974). 50 million dollars was budgeted for 1975, and 55 million dollars for 1976 (Report to the Congress, 1974).

The Greeley clinic is one example of a project

developed through funds made available by the Migrant Health Act (The Student Health Program itself is funded by the Robert Wood Johnson Foundation, not by the federal government.). 80% of its budget derives from HEW; the remainder comes from the city of Greeley, the Colorado Department of Health, and patient fees (Grant Application, 1974).

In an excellent sociological study, Saunders (1954) analyzed the interactions of rural Spanish-American patients and Anglo medical personnel. He concluded:

The points made here about better health programs for rural Spanish-speaking people are very general. They are deliberately so. The purpose of the discussion has not been to draw up a blueprint for an ideal program, but rather to call attention to the fact that the success of any program will depend less upon the quality of its paper plan or the perfection of its organizational scheme than upon the interest, imagination, social perceptiveness, and human warmth of the people who staff it.

From my own retrospective efforts as well, I have learned the importance of the very personal level at which health workers interact with each other and with patients. At the next level, we were all members of cultures and subcultures, and the actual outcome of our interactions--"health care"--depended upon the values we had culturally acquired. Then too, we were Americans, and our values reflected certain national themes of health care, economic opportunity, and social justice.

A number of other migrant health workers have offered suggestions for the future which are based upon their own experiences. Few of these are directed only at the level

of local health project planning. Many encompass the area of personal values that must be changed, on the part of both health workers and migrant patients, if better health care is to become a reality. On the other hand, many also encompass the area of national health policy for migrants, since local projects must rely upon national legislation and funding. This area, in turn, cannot be separated from economic and social planning for other aspects of migrant farmworkers' lives. Nor can health policy for migrants be separated from health policy for all Americans.

FLEXIBILITY IN MIGRANT HEALTH CARE

As Saunders has pointed out, most health workers are trained in scientific medicine and in urban hospital centers. They are also trained to think of their own professional roles in limited ways. In bringing health care to a different cultural group, health workers must learn, above all else, flexibility.

Flexibility in health services. Migrant farmworkers usually live far from conventional health facilities, and they must also lose several hours of needed wages if they visit a physician during conventional office hours. To overcome the problems of distance, some health projects have used mobile clinics, which are especially practical in areas with large labor camps (e.g. Darrah, 1962; Emeline, 1968; Gangitano, 1972). These projects have also employed public

health nurses to travel to migrant labor camps and homes to give follow-up care. In other projects, nurses have been responsible for case-finding as well (Uhde, 1964; Chladek, 1965; Harper, 1969). Medical students who have been willing to view their own roles with flexibility have performed the same tasks in some projects (Bergstrom, 1962; Harkness, 1969; Gangitano, 1972). All these health workers have found, as I did, that visits to migrant families are extremely important in accomplishing follow-up care for health problems, not only because of their geographic isolation but also because of their cultural attitudes.

As at the Greeley clinic, night clinics have been a common adaptation in migrant health projects (e.g. Chapman, 1964; Gangitano, 1972; Fuentes, 1974). Weekends are another time when farmworkers may use health facilities more readily. Our Sunday clinic in Burlington was heavily attended, and a few others have reported similar successes with weekend sessions (Siegel, 1963; Moses, 1973).

Many workers have stressed the importance of planning transportation as a part of migrant health services (e.g. Harper, 1969; "Health of the Migrant Farm Worker", 1971). Where clinics for farmworkers exist, patients must be able to reach them. In rural areas, referrals may involve sizable distances; transportation often must be provided to migrants in need of specialty care. At the Greeley clinic, two outreach workers devoted part of their time to bringing patients without their own transportation to the clinic or to

specialists in Greeley. They also drove regularly to Denver to bring patients to outpatient specialty clinics at the medical center, and occasionally they drove patients to Denver for inpatient care. Because so few farmworkers have telephones, the outreach workers sometimes served a vital communication role. At other times, their involvement in patient care was important.

One of the outreach workers, a former farmworker, was essential to the care of a set of triplets, born in the spring to a migrant mother. Juan not only transported the mother to Denver for a television appearance but also translated for her on the show. The publicity resulted in gifts of formula and clothing for the triplets and money for the clinic, which would otherwise have had to deplete its limited hospitalization funds for the expensive inpatient care of the premature infants. Later, Dr. Barra heard that the parents were about to depart for Texas. Because one of the infants was still too frail to survive the trip, she despatched Juan to find the family. He found their house already empty but, using his intuition, he tracked them down at another family's home and persuaded the parents to delay their departure.

Flexibility in picking a site for well-child care has brought added health services to farmworker children. Our own efforts, and those of other health workers (Dougherty, 1971; Eisner, 1972) have shown that, when necessary, well-child and acute care can be provided within a school setting.

Others have emphasized the importance of day-care centers, not only as a base for health care but also as a setting in which malnutrition can be combatted (Siegel, 1964 and 1966; Fuentes, 1974). Although day-care and school programs may be adequate settings for health care, I found that parents were not appropriately involved in their children's health care in these locations. Gilbert (1963) successfully initiated a "child-oriented health education program" through evening and weekend meetings with the parents of migrant children in a summer school program. If we had arranged our priorities differently, we too could have involved parents to a greater degree.

Migrant health workers must concern themselves at times with problems not conventionally considered within their domain. Since most migrant health problems result from economic and social deprivation, this flexible approach makes sense. Recreational facilities for migrant farm-workers are badly needed and would probably reduce the incidence of alcoholism and violence ("Health of the Migrant Farm Worker, 1971). In the Puyallup Valley of Washington, health workers actually helped to start recreation programs, with the result that "drunkenness and lawlessness have declined incredibly" ("Children of Noplace, U.S.A.", 1961). At the Greeley clinic, I saw only one family in which drinking and physical violence were evident. But I do not know the true extent of these problems in my patients.

The migrant families enthusiastically attended

two fiestas, one at the church and one at the school. Other recreational programs probably would have received a good response, and these might have been effectively coordinated with programs aimed at greater involvement of parents in their children's education and health care. Teenagers seemed especially in need of recreational programs. Several whom we befriended were always eager for more volleyball games and singing sessions, which migrant ministry workers had organized. Because their homes were so isolated, they had little opportunity to get together after their days of field work. I do not mean to ignore the rich personal relationships which these teenagers seemed to experience within their own families; but if they are ever to join more fully in a broader social experience, they must be exposed to it.

One California health project took a flexible approach and became a "catalyst" for other social services by offering agencies space at its clinic. Employment counseling, legal aid, emergency food stocks, and welfare services, as well as a Spanish-speaking sanitarian, became available to area farmworkers in this way (Harper, 1969). At the Greeley clinic, a Spanish-speaking social worker, provided by the town welfare department, spent one evening a week at the clinic.

Flexibility in health professional roles. I happen to enjoy working without clear role boundaries. I also

believe that role flexibility brings not only personal satisfaction to health workers but more health care to patients. Harper (1969) has written of a successful migrant health team:

. . . Of salient importance in the project were the principles of organizational flexibility and of establishing a working atmosphere conducive to the entire staff's responding creatively to needs without arbitrary or traditional restraints.

Health teams are especially important in providing care to the rural migrant population. Physicians able or willing to provide migrant health services are scarce, and other professionals must perform tasks traditionally restricted to physicians if these tasks are to be performed at all. Furthermore, the large Mexican-American migrant population is culturally accustomed to receiving health care on a level closer to the "personal" than the "professional". Physicians who are unwilling to perform some tasks ordinarily relegated to nurses will probably not create a social atmosphere to which the farmworker is likely to return.

The need for a new health professional role has emerged from the cultural gap separating migrants and medical personnel. Two California migrant health projects have successfully employed health aides indigenous to the Mexican-American farmworker population which the projects serve (Siegel, 1966; Gangitano, 1972). I have already emphasized the importance of such workers at the Greeley clinic. In China, a remarkable national health program has raised the largely rural population out of overwhelming disease to

good health in only 25 years (Horn, 1972; Sidel, 1974). Crucial to this progress was the training of many "barefoot doctors" who returned to their communes to provide primary health care as they continued their agricultural work.

In considering the health problems of migrant farmworkers in their state, members of the Illinois State Medical Society resolved to urge the American Medical Association "to make every effort to obtain federal and/or other funds to establish a health care training program for migrant workers" (White, 1973). Although they must have realized the irony of asking the A.M.A., of all organizations, to establish training programs for "barefoot doctors", these physicians recognized that health workers who continue to travel with the migrant streams could serve as health advocates for migrants, offer temporary care until more definite care could be found, direct families to existing medical facilities, interpret their needs to the medical community, and extend prescribed care to families as they move.

Unfortunately, indigenous health workers will not be widely accepted by the medical profession until other related, and limiting, attitudes have changed. It must be remembered that China trained "barefoot doctors" in a society which emphasizes that every citizen--not only the physician and health worker--has the right and duty to learn about health and contribute to its maintenance. The concepts of equality that underlie the Chinese health system are

important in the flexibility of both health worker roles and patient-health worker relationships in that country.

Many workers have stressed the importance of health education in overcoming the health problems of farmworkers (e.g. Gilbert, 1963; Afek, 1972). In their isolation from the general population, migrant farmworkers have remained poorly educated and ignorant of ways in which they might improve their own health. Flexibility is important in health education as well. Fuentes (1974) has suggested the use of educational materials written on the sixth-grade level in Spanish as well as English, Spanish-language newspapers and radio stations, and educational movies already available from Mexican film companies at reasonable cost.

Because of their mobility, migrant farmworkers need a well-functioning system of records and referrals to health workers in various locations. The confusing inconsistency of services provided in different areas, the lack of any services at all in some areas, and the degree of unpredictability in migrants' plans, are all major obstacles to an adequate referral system. In a project developed in conjunction with a Family Practice residency program, problem-oriented health records were given to the leaders of subgroups with different destinations (White, 1973). Because changes in travel plans led to the separation of some patients from their own records, it was decided the next year that heads of families should carry the records. Browning (1971) studied 4,110 referrals made through the

Migrant Health Service Referral System, which involves 180 "migrant" counties on the East Coast. 61% of the referrals resulted in patient-health worker contact; 84% of the contacts resulted in health services rendered, and in 70% of these, complete service (as requested by the agency which had made the referral) was given. Of the 39% of referrals in which no patient-health worker contact was made, the patient could not be contacted in 80% of cases. In these cases, migrants may have lost interest in health care as well as changed their itineraries, or the referring agency may not have provided adequate information for the receiving agency to locate the patient. The authors concluded that, contrary to popular belief, the migrant does not wander aimlessly; since he can usually name his next stop to a health agency, a health referral system is feasible and should be emphasized on local, regional, and national levels.

In a study of California migrant farmworker families who were issued health records, three-fourths of the respondents could produce the record upon request of the researcher (Zusman, 1964). But very few knew what the health records were for. They did not show the record to health personnel, even when they had it in their pockets, unless it was specifically requested. Health personnel, in turn, had not been properly educated about the use of the record. Afek (1973) concluded about an interagency referral system in Arizona: "An important part of the referral process is educating the patient by helping him to comprehend the

nature of his health problems and what action is desirable and necessary." In Florida migrant health projects, every health worker is considered to be a health educator ("Health of the Migrant Farm Worker", 1971). In order to carry out "doctor's orders", all patients must comprehend their health problems and treatment plans; migrants have the additional burden of comprehending what health care is actually available to them in different locations. Health education is crucial to providing continuity of care to migrants.

Flexibility in attitudes about health and disease.

To plan treatment which the patient will actually carry out, health workers must understand a patient's cultural attitudes. Saunders (1954) has written about the cultural attitudes which Mexican-Americans bring to their contacts with health personnel. Folk ideas about health and disease can be an obstacle to the delivery of health care. For example, patients suspected the nurses in one health project of using the "evil eye" (Harper, 1969). But Martinez (1966) found that even urbanized Mexican-Americans still rely upon a system of folk beliefs and curative practices, and upon Anglo physicians and medical facilities as well. Saunders noted a similar dual reliance among rural Spanish-Americans in Colorado.

When health personnel understand folk beliefs, they can incorporate them into "scientific" treatment plans. For example:

If a pregnant woman comes to the clinic with a string tied to her waist . . . just say, "Well, make sure that the string is clean and not too tight, and to help it take these pills or use this ointment." (Fuentes, 1974)

A Colorado farmworker expressed a similar idea in a video-tape shown to Student Health Program workers. He said that many Texas migrants prefer to see physicians in Mexico because they are less likely to ridicule a patient's own attempts to cure his disease. If a migrant mother has been giving her sick infant an herbal tea, an American physician is likely to discount the value of her efforts. But a Mexican physician will say, "That's very good, but give the baby these pills with the tea to make it stronger."

Afek (1972) has reported a successful health education project in Arizona labor camps, where health workers had to acquaint themselves with three separate cultures: black, Mexican-American, and Papago Indian. Instead of discrediting folk beliefs and cultural attitudes, workers organized informal health education groups and used "friendly persuasion" to teach mothers to incorporate commodity and nutritional foods into their accustomed diets and to accept prenatal care and other health practices.

Saunders and Fuentes have suggested that health professionals work with lay practitioners to develop rapport between health agencies and the patient population. A "curandera" who lived near Greeley often referred patients to the clinic, and she herself was a patient there. Saunders has pointed out certain fears of Mexican-Americans which

often cause them to avoid Anglo health personnel in favor of folk practitioners. These fears stem from a desire to see a practitioner who understands the patient's own concept of disease and treatment, involves the patient's family in treatment plans, and approaches the patient on a personal level.

Many workers have emphasized the importance of drawing a Mexican-American family into the treatment plan for one member (e.g. Saunders, 1954; Fuentes, 1974). In Greeley I realized quickly that my patients were more comfortable with this approach. I also learned more about a specific health problem from several interested informants, and my treatment plans were more likely to be carried out.

The most important point about cultural attitudes is that conventional "professionalism" will not work. The Mexican-American's cultural heritage has shaped his reliance upon personal relationships in health care (Saunders, 1954); but the literature suggests that other migrant subgroups also appreciate a more personal approach. I will quote two other migrant health workers because their words echo my own experience:

. . . (the public health nurse) learned that when she sat down in the home and took sufficient time for the social amenities so important to a person of Spanish-American culture, it was not long before the entire family became involved in discussing their health problems. (Chladek, 1965)

It has been my experience in working with migrant laborers that it is often a feeling of friendship for the physician that is more important in keeping the patient returning to clinic until treatment is completed than the physical problem the patient is

experiencing. (Gangitano, 1972)

Saunders has advised:

Relationships and procedures should be made as informal as possible, and there may be times when efficiency needs to be sacrificed for informality . . . The personalities of the physician and nurse are important factors . . . If a choice must be made, it may be better--at least in the early stages of any program--to give greater weight to personality factors than to professional qualifications . . .

More concretely, Fuentes has suggested that doctors and nurses "mingle with them" and "participate in sport and social activities." Such advice may sound heretical to many health professionals who, Saunders wrote, have particular difficulty in introducing flexibility into the "limited range of circumstances" in which they learned to practice medicine.

At times I wondered if something was "wrong" with me because I preferred to be "personal" rather than "professional" in a medical center setting. Saunders' analysis has helped me to understand why I had been uncomfortable with my professional role at Yale and why I was more comfortable with it in Greeley. Fortunately, Saunders has offered a definition of "professional" which is not taught at Yale:

. . . In the treatment of disease there can be no compromise with the highest professional standards; in the treatment of people there may have to be some compromise if the treatment relationship is to be accepted. Part of the inflexibility is due to failure to recognize that the social circumstances in which medical care is given do not necessarily influence the content of that care . . .

I will never again wonder if a physician loses a patient's respect by taking a warm and personal approach.

Flexibility in planning migrant health services.

The lesson of personal relationships has a counterpart at the political level. Many articles by health workers attest that, as individuals, migrant farmworkers respond positively to health education and care when these are offered in a manner respectful of their own attitudes. Migrant health projects have also provided statistics to disprove the common belief that migrants have no interest in improving their health. A volunteer clinic in California attracted only 88 patients in its first three months of operation but, several years later, saw 1,333 patients in the same period of time (Jessup, 1960). A clinic in Idaho had 600 patients within two months of opening ("Clinics for Migrants", 1972).

On an organizational level, migrants have been demonstrating that they want to improve their health status--and that they want to help plan its improvement. Fuentes (1974) has listed many ways in which health workers can avoid ethnocentricity at both the personal and the organizational levels. He advises: "Attempt to serve people's needs from the standpoint of their own frame of reference." Moses (1969) has expressed the same idea with appropriate anger:

Let me tell you something: the poor are no different from you and me--they know a good thing when they see it. So, if they aren't using something, it's because it's not helping them, it has no relevance to their lives, it's not meeting their needs.

In Florida, migrant farmworkers have been participating successfully in the planning of health services through elected representatives on Project Policy Boards ("Health

of the Migrant Farm Worker", 1971; Johansson, 1972). Members of the United Farm Workers in California have built, and now operate, a union health program (Moses, 1973). Although health consultants helped to develop the program, the workers decided which benefits they wanted their limited budget to cover. Elected committees at each ranch process all claims. By enforcing the plan themselves, the committees are able to educate union members on their rights and responsibilities.

At recent Senate hearings on migrant health legislation, several speakers pointed to a need for increasing consumer input into migrant health projects (Hearings Before the Subcommittee on Health, 1974). Because of their social isolation, lack of education, and accustomed lack of planning in the face of constant unpredictability, migrant farmworkers need training in effective consumer advisory work. At the Greeley clinic, members of the Consumer Advisory Board had apparently used this kind of training to progress from nonfunctional fighting to effective decision-making. Speakers at the Senate hearings asked that funds be legislated for this specific purpose. When the Health Services Act was subsequently passed, it included a "mandate" for consumer participation in projects which would be funded (Report to the Congress, 1974).

OUTSTANDING NEEDS IN MIGRANT HEALTH CARE

More money for home-base areas. At the 1974 hearings, speakers focused on several issues besides that of consumer power. They asked for more money, of course. Daniel Hawkins, director of a farmworker clinic in Texas, pointed out that the cost per individual for comprehensive health services is considered by experts to be almost \$200. The 1974 allotment for migrant farmworkers was less than \$15 per individual.

Given the expected budget, a number of speakers felt that available funds were not going to areas where migrants spend most of their time. Hawkins cited two demonstration projects which showed that Texas migrants utilize more health services at home than in the stream; other migrant health workers have also pointed out this discrepancy (White, 1973; Campbell, 1974). In Colorado, I was continually struck by the lack of home-base health facilities which patients reported. Senator Yarborough has testified that, while the federal government spent \$3,564,000 in 1967 on the health of animals in Hidalgo and Cameron Counties in Texas, it spent only \$419,000 on the health of migrant farmworkers in these two home-base counties (Migrant and Seasonal Farmworker Powerlessness, 1969).

Several speakers at the 1974 hearings urged that migrant health legislation direct most of the available funds to home-base areas. The legislation under consideration was

to fund comprehensive "migrant health centers" in "high impact areas", defined as counties which have at least 6,000 migrant farmworkers and their families residing therein for more than 2 months of the year. Hawkins urged that 6 months should be the minimum acceptable period for this piece of the legislation. Dr. James Perrin, who had worked for two years in the central office of the migrant health administration, called for a similar rewriting of the legislation. He estimated that 50% of migrant health funds were being spent in "upstream" states, even though about 70% of migrant farmworkers' time was spent in their home-base areas. Both Hawkins and Perrin suggested that the Midwestern and North Central agricultural states, where migrants work only transiently, have used political power to prevent available funds from being spent where they would do most good. Unfortunately, the legislation was subsequently passed with the original 2-month stipulation for high impact areas.

More money for hospitalization. A major problem in migrant health care is the lack of funds for hospitalization. Many health workers have pointed out the difficulty of providing migrants with inpatient services. In 1957, 1.2% of the migrant farmworkers in one state were found to be in need of public assistance, usually hospital care, during their stay there. The agricultural economy of the state was valued at one billion dollars, and over \$91 million was paid in the same period for public assistance to state residents.

Less than \$100,000 would have covered the migrants' need, but they were not eligible by state law to receive it (Johnston, 1965). A national evaluation team reported that exclusion of migrants from hospital care was "the principal deterrent to adequate care" (Johnston, 1966).

The 1974 migrant health legislation lists hospitalization as a "supplemental" service (Report to the Congress, 1974). Olga Villa, Director of the Midwest Council of La Rasa, said at the hearings:

. . . I cannot conceive of hospital service being anything but primary . . . many migrant farmworkers are in acute need of hospitalization and yet services are sometimes discouraged because of the lack of funds for hospitalization.

Student Health Program workers were similarly hampered by lack of hospitalization funds. One health team was forced to send a farmworker in acute congestive heart failure back to his home, sixty miles away, and then follow his condition through home visits. The hospital in town would not accept migrant patients because it was unwilling to cover their hospitalizations financially. The medical student telephoned Colorado General Hospital in Denver but was told by the admitting intern that the patient could not be admitted there because he was not an interesting teaching case. If health workers were persistent in their efforts, migrant patients could sometimes be admitted to Colorado General Hospital, but the state legislature had taken the hospital to task for accepting indigent out-of-state residents. Patients at the Greeley clinic could be admitted to the Weld County Hospital

for deliveries and serious conditions. This hospital covered some migrant hospitalizations with federal funds received through the Hill-Burton Act, but most county hospitals have been reluctant to do so.

Because most counties and states are not willing to accept financial responsibility for the hospitalizations of migrant farmworkers, Hawkins urged at the 1974 hearings that a separate federal fund be established for migrant hospital services. A Migrant Hospitalization Demonstration Project is currently determining the hospitalization needs of migrants, but no special funds have yet been legislated (Report to the Congress, 1974).

Need for coordination of health services. A common complaint at the 1974 hearings was the lack of coordination between the various federal agencies involved in migrant health care. Speakers called for the establishment of a National Advisory Council on Migrant Health, which would include farmworker representatives. The Comptroller General's report (1973) also noted a lack of coordination and suggested that a national council could tie together the services of the federal agencies. Health workers have reported some of the local consequences of this lack of coordination (Harper, 1969; Fuentes, 1974). While more than one agency may provide the same health service for migrants, other needs go entirely unmet.

Need to enforce existing legislation. Lucia Pena,

an Oregon community organizer, reminded legislators at the 1974 hearings of a major problem that continues to block the effectiveness of migrant health programs. She emphasized that migrant health projects should not have to use funds allotted for "supplemental health services" to police the enforcement of existing legislation (Hearings Before the Subcommittee on Health, 1974). I have provided evidence in the preceding chapter that laws governing Food Stamp programs, pesticide control, and housing and sanitation standards have not been enforced. As a consequence, migrant farmworkers have continued to live and work in unhealthy environments.

A BROADER VIEW

The struggle of farmworkers for power. Many health workers have realized that their own efforts must be accompanied by broader social changes. Gilbert (1968) has written that, "until agricultural workers become part of the mainstream of national economic and cultural life," their health will remain a serious problem. Moses (1973), who worked as a full-time volunteer nurse with the United Farm Workers during their years of struggle for recognition, also realized that health care is meaningless in a context of powerlessness. She temporarily suspended her health care efforts to join in the union's struggle:

I was being told that the best way to give medical care to farm workers was to stop giving direct care myself . . . I can still hear Cesar saying with gentle

exasperation, "Marion, what good will it do to have a clinic if we don't have a union?" I went on the boycott.

Nelkin (1970) has pointed out that most social work projects for migrants, as well as health care efforts, have been directed toward making the migrant's current situation more bearable so that he will continue to be invisible to the nation's social conscience. Because migrants themselves fear upsetting the precarious balance of their existence, they themselves have also avoided visibility within the towns of mainstream America.

A decade ago, an American Journal of Public Health (1964) editorial stated: "Poverty-enforced migrancy is not compatible with health, general well-being, or with our democratic society." It recommended that the agricultural work force be stabilized, financially and geographically, to eliminate the need for migrancy. Nelkin has reviewed a number of proposals for this "promising approach." Central to these proposals is the acquisition of power by migrant farmworkers:

There are several implications of the . . . proposals. First, that the migrant labor force is an industrial labor force in which stability can be developed through adequate remuneration; money and mobility, rather than manipulation of basic needs, must be the means of management . . . A further implication is that significant change in the migrant labor system will require that farm workers be in a position to share the rights, privileges, and resources of the larger society. Without such power, specific limited improvements are merely frosting on an unpalatable cake.

Taylor (1973) also believes, along with Cesar Chavez of the United Farm Workers, that "a satisfactory full-time work

cycle"--with decent wages, housing, and health care, and with regular school attendance for their children--is possible for farmworkers.

Nelkin has stressed that fair labor practices will not be extended to agriculture without either strict government regulation or a more equitable distribution of bargaining power. But the federal government has consistently withheld regulation from farmworkers. Until 1964, the federal government administered "bracero" programs: Mexican men were imported for the harvest season to work at very low wages, while domestic farmworkers went unemployed. After the bracero programs were phased out, growers continued to find other cheap sources of labor. The federal government legislated the McCarran-Walter Act, which allows large numbers of Mexicans (the "green-carders") to work in the United States (Matthiessen, 1973). For the past thirty years, an amendment which excludes farmworkers from the National Labor Relations Act--and thus from collective bargaining rights--has been renewed annually. Many farmworkers are also excluded even from the minimum-wage (\$1.30 an hour!) and child-labor provisions of the Fair Labor Standards Act. In most states, they are excluded from unemployment insurance benefits, disability benefits, and workman's compensation (Law, 1974).

Such government regulation has actually perpetuated the domestic farmworker's plight. The Rio Grande Valley, for example, grows \$100 million worth of produce annually.

But the farm work there is not done by American farmworkers. When farm work becomes available each spring in the Valley, thousands of Mexicans cross the border legally and illegally. The cost of living is low in the Mexican towns across the border, and they can afford to work for low wages. The "Tex-Mex" farmworkers, who must earn more to survive on this side of the border, cannot compete for the available jobs. They leave their homes and travel north in search of work (Taylor, 1973). Thus Texas is, paradoxically, the largest user and the largest exporter of migrant labor in the United States (Moore, 1965).

Because the government has consistently legislated against farm laborers and in favor of powerful agricultural industries, some farmworkers have looked to unionization as their only hope for gaining some control over their lives. Agriculture is an industry. Commercial farms have grown so big that half of our produce is grown on only 9% of the nation's farms (Moore, 1965), and the largest farms use the most migrant labor. Farmworkers deserve the legislative protection that all other American industrial workers now enjoy.

The obstacles to the unionization of farm labor are great. Cheap Mexican labor continues to be available, and growers continue to wield tremendous political power. The American public has been reluctant to support the unionization of farm labor for fear of increasing food prices, even though field labor contributes very little to the retail

price of produce (for a head of lettuce sold in 1965 for 21¢, the field labor cost was 1.2¢) (Moore, 1965; Matthiessen, 1973). The geographic isolation of workers dispersed over many farms, and the seasonal nature of the work, have made unionization efforts extremely difficult. Moore (1965) has described another factor which makes many farmworkers reluctant to join a union:

Few workers think of themselves as permanently in the farm labor force . . . Most would leave the field for good if they were able to. Joining a union makes it psychologically "for keeps," and many cannot do this. Although many field workers do not personally object to the work, they are not unaware of the low esteem society places on it and those who do it.

The United Farm Workers won their long battle against California grape growers in 1970. More recently, however, they have lost most of their contracts to the Teamsters. Farm labor continues to be ruled by the powerful growers, who signed "sweetheart" contracts with the Teamsters rather than allow the farmworkers to decide upon their own union representation. As Griffith (1974) has pointed out, "the struggle for the individual farmworker family is far more a matter of physical necessity than political decision." To provide for their families, farmworkers continue to be forced to work whenever and wherever they can.

Some California farmworkers now enjoy a few benefits of unionization. But a more basic issue remains unanswered. The argument which occupies the press--that Chavez has served a missionary purpose but the Teamsters' organization can now represent the farmworkers more efficiently--has

obscured the conflict between two different concepts of democracy (Taylor, 1975). The fundamental unit of the United Farm Workers is the ranch committee, elected by the workers on each farm. Teamster officials, on the other hand, "have made it clear that field workers will hold no membership meetings nor conduct any elections for years to come." "Who controls the work force?" Taylor asks. Unfortunately, agribusiness does, once again. By abolishing the hiring halls which the United Farm Workers insisted upon, the Teamsters have allowed growers to return to labor procurement patterns which previously kept farmworkers in powerlessness.

The struggle of American health consumers for power: my view from here. Migrant farmworkers are a dramatic example of economic exploitation in this society. But they are not alone in their lack of power in the face of industrial interests. Nor are they alone in demanding an increased voice in the planning of their own health care. Waitzkin and Waterman (1974) present evidence that all Americans are deprived of better health care by "medical imperialism", which is motivated not only by economic greed but also by desire for prestige and power. Within the institution of medicine, professionalism, elitism, and limited communication to patients have served as mechanisms of stratification (The Exploitation of Illness in Capitalist Society, 1974). In other words, patients have been kept in ignorance about health and disease, and in awe of the medical profession. Although our society is far too different

from the Chinese to transpose their solutions to our problems, Sidel and Sidel (1974) have pointed out several specific ways in which our own health system might "serve the people" rather than already powerful medical institutions. The most important general lesson to be learned from the Chinese experience is that health workers and the general population, working together, can accomplish tremendous feats in health care if they are so motivated. That some citizens of this country must endure a health status as neglected as that of migrant farmworkers is blatant evidence that this society is not so motivated. Until the priorities of this society change--until, as Sidel and Sidel write, the concept of "service as an end in itself rather than as a means to private gain" permeates every corner of this society--the health care system within this society will not serve the needs of the general population. Waitzkin and Waterman have also viewed the practice of medicine within its societal context:

. . . Stratification in medicine is grounded in the class structure of a society. As we have seen, medical care is one dimension of social stratification . . . Overcoming medical stratification will ultimately depend on broader sociopolitical changes in society . . .

Broader changes take time. Meanwhile, health workers can decrease the stratification within medicine. We can educate our patients as fully as possible about health and disease. We can listen to their own expressions of their needs, both as individuals seeking personal health

care and as consumers seeking a part in the planning of health care. We can urge that national health legislation go much further than national health insurance, which will not change the distorted priorities and basic inequities of our present health care system.

Broader views are frighteningly complicated. In trying to settle upon a way of approaching the particular problem of health care for migrant farmworkers, I have felt discouraged. Health legislation will not bring health to a group of people forced to live in the unhealthful conditions of poverty. The "health" problem of migrant farmworkers in this country is an ideological problem, and its solution will evolve only out of economic security, political power, and social respect for farmworkers. My personal values will probably keep me at work in the health care system, and I will probably continue to feel satisfied by the personal rewards of that work. But I know that I will continue to feel frustrated as well--angry and, at times, hopeless--by the parameters within which I must provide health care. National priorities are not likely to change quickly, nor can differences in cultural values be resolved easily. It is all very well to care for migrant farmworkers for two months and leave with tremendous anger over their exploitation. But I do not know how I will feel after years of frustration. Was Dr. Barra just as idealistic when, as a medical student, she left her summer of work in the Student

Health Program? When I have struggled several years with different personalities and cultures, and against the prevailing winds of capitalism, perhaps I will be more like her. And as I receive more training in "doctoring", I may lose the warmth and intensity I so much enjoy now with patients to a humdrum exchange of technical skills and quick smiles.

Hopefully I will learn more in the next three years than technical skills. Arnie and I have tried to choose Family Practice residency programs in which we will learn as well about the health care consequences of personal interactions, social environments, and political influences. But we may be disappointed. These programs are new, and they will need more time to realize their promises of personal sensitivity and community awareness within a traditional medical center setting.

And after that? We talk about working in a rural area, and one part of my mind sees me in the Rio Grande Valley. But whatever we do first will most likely be an adventure of some sort, nothing permanent. We both wonder how long we would be happy in a culture that is basically not our own. No matter how we analyze our middle-class, achievement-oriented, intellectual roots, would we nevertheless be lonely without middle-class, achievement-oriented, intellectual friends? Another fantasy that appeals to us--perhaps because it combines roots and ideals--is sharing one position in a group practice and then devoting time to

a community clinic which is experimenting with more egalitarian concepts of health care.

In planning for the next three years, Arnie and I have already made compromises. If we want to live and work together, we will probably have to make many more. And I have not even begun to imagine how my ideals will be challenged by the children we would like to have. There must be a thousand decisions of time, geography, and life style that parents must make, and I imagine that my ideals for health care work will sometimes conflict with my ideals for my family.

When I began medical school, I was terrified of being socialized into personal callousness and political conservatism. I have been socialized in some ways, but I think now that I have not lost the convictions for which I had most feared. Yet somehow that does not convince me. Now my fears have less to do with formal training, but more to do with relationships. I know already that it is hard to work out ideals with real, and needed, people, whether in work or in friendship. I am still learning how to work and dream at the same time.

NOTES

1. In talking to Karen about the ways she related herself to her background, I came to understand more about the ways I myself had tried to replace some values I had learned without tearing out my very roots. I had long since rejected as hypocritical, and bitterly, my own religious upbringing. Ethics had been conveyed to me more in political than in religious terms: our rabbi had been on Freedom Rides with Martin Luther King, he gave lectures on socialism and his visits to Russia, he was proudly picketed by the Connecticut Anti-Communist League, he even put in a word about Watergate when he married me. But his congregation was no different from any other. They packed into the shining Temple each Yom Kippur and then, assured that they were liberals by an annual political sermon and their sizable dues, they spent the rest of the year making plenty of money off other people.

But, despite my bitterness, I had obviously retained something from the words of the rabbi: a framework of ideas, perhaps, about socialism and civil rights which I had continued to explore in the hope of finding a specific set of values that felt comfortable to me. Now I was trying to relate myself comfortably to another powerful institution and to decide which of its values I needed in order to work and which I could not work with at all.

2. It is not coincidental that Karen's relationships with men were changing as she planned career changes. Like me, she was growing beyond wishing for the magical fulfillment of marriage (It amazes me now that I was still wishing for just that when I graduated from college!). In fact, she was rather bitter about marriage per se, for both her older sisters had already been divorced after marrying young and unhappily. But her bitterness had, in the end, been a constructive stepping-stone to distinguishing between the myths of marriage and the real rewards of an intimate friendship. It was almost uncanny that she was now having a close and happy relationship with a young man whom she had known previously as a friend, for my relationship with Arnie had also begun without the confusing trappings of courtship. We had valued the real giving and receiving of our friendship before we wondered whether this was "it", whether this seed would sprout the securities and threats of life-long commitment.

What rights do thoughts of love have to intrude on a senior medical thesis? What I value in my work, and

what I question in it, can never be separated from what I have been taught to value by my family and society and what I have not been personally afraid to question. I was taught that medicine was a man's work and that a family was mine. There is no question that I was taught to think of myself as inferior to men. I came of age at the right time for riding into medical school on the crest of the women's movement, and I do not think that without the supporting societal changes I would have had the strength to challenge that inferiority. The waves that moved me toward expecting career options equal to a man's were the very same waves that moved me toward expecting equality in an intimate relationship with a man. When, in my marriage, I come to understand some way in which I fear Arnie's power, I reap benefits in my work, for I do still fear men in general in some ways, and my timidity often keeps me from more actively learning for myself or helping others. When, in friendships, I come to understand ways in which I fear other women, I again reap benefits by working more productively with other women, with less energy wasted in tension. Perhaps this integrated way of thinking comes more easily to women, since we are expected to fit our professional lives to our personal lives, while most men in medicine seem to operate in reverse. It is my way of thinking, at any rate, and sometimes I think I have kept too quiet about it. There is a real loneliness, and real anger, to feeling that sometimes my whole way of thinking, and not just my voice, is in an alien range.

3. I have structured my world in order to survive it, and I have been most "honest" with the people who understand my structure. I have fully revealed it only to those who did not threaten to topple it with attacks of contrary values. Should I call this "honesty"? But I must accept what I have built, even though I must always be learning what of it is basic and unchangeable for me and what can, ought to be, changed as my environment changes. When I did not yet have this kind of self-acceptance, I felt worthless, and I would not like to feel that way again. I try to understand other ways of looking at the world, other ways of structuring existence, and if another way is like mine but a little different, I can take something from it, perhaps use it to change my own way of seeing. But if it is too different, I discard it, I wrap it up in an anecdote, amusing but scornful, and throw it out to friends who see things my way. I'm just like everyone else. I can't stand to be too threatened. I structure an existence I can't understand, then I try to defend it. But there are moments when the non-understanding of existence bared surfaces into my structure and topples it anyway. Then my values are nothing, and they mean nothing to me.

4. I think now of how I have lost myself, in museums, in Dubuffet's sculptured figures, with their crazy, interlocking and overlapping forms. Perhaps I have subliminally perceived them as movements of concrete, well-bordered parts into wholes that live, speak, and beguile. I would not deny that my configuration of my social system reflects changes in my own personality over the past few years. When I identified myself most strongly with political activism, I was also tremendously unhappy. I was always longing for something I could not define, something revolutionary, that would immediately and smoothly fill out the lack I felt. Superficially, there was something of this in my decision to go to medical school. I was participating in a graduate seminar discussion of Melanie Klein's psychoanalytic theories. Suddenly I knew that I would not be satisfied with less than medicine. It was my father's life, and one keenly valued in my home--but not for me. At the time, I was working at a hospital for emotionally disturbed children, and I was almost infatuated with the ability of the child psychiatrist there to receive our thoughts about, and our emotional reactions to, a child, and then to organize them into a whole, so much smaller than all the counselors' and teachers' comments and yet so much more exciting, with all the parts meaningfully related to each other and to the whole. But I needed Melanie Klein. I remember thinking in that class that she was a great woman, and that I wanted a measure of greatness, too. A few hours after the seminar ended, I had already found out how many premedical courses I would have to take that year and where I could take them.

Of course I see now that this revelation came to me only at the end of years of the grinding out of conflicts. Most were unconsciously and symbolically expressed, for my only memory of having ever thought previously about going to medical school is one moment of intense jealousy of some medical students I had met when I started graduate school. Some important conflicts came to my understanding in women's groups. Most of us had withdrawn from a larger political group as struggles for dominance, by men, continued to guide its dynamics. Most of us were not as aggressive or glib as the men, and we were beginning to look for other ways to feel our own power. We complained about our oppression as women, and fortunately I was able to understand how I contributed to it. I realized that my own fear of asserting myself, as well as my society's standards for women, had kept me from applying to medical school. Other hindering conflicts ground themselves out in my relationships with friends and with my parents and sister, as they must for all young people moving toward their own truths.

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Appendix A

ORGANIZATIONS INVOLVED IN MIGRANT AND RURAL HEALTH CARE

The following information was distributed to Student Health Program members before they arrived in Colorado. It provides a helpful explanation of the various organizations involved in migrant health care in Colorado.

My own health team interacted with all the agencies listed, except the United Farm Workers and Colorado Rural Legal Services. There was no active United Farm Workers branch in the Greeley area. Colorado Rural Legal Services did maintain an office in Greeley, but our time was so limited that we did not initiate any interaction with this agency.

ORGANIZATIONS INVOLVED IN
MIGRANT AND RURAL HEALTH CARE

Introduction

I. Student Health Program for migrant farm workers and rural poor:
Relationships with migrant help agencies in Colorado.

Although the Student Health Program is based out of the University of Colorado Medical Center, the successful impact of the program is based on the fact that it is part of a multi-organizational approach to migrant health care in the state. Coordination and cooperation with the other involved agencies is essential in improving health services to farm worker families. The importance of inner-organizational theory and its application to the Student Health Program's integration with other migrant help agencies will become increasingly obvious to you as you participate in the Program. It is only through cooperative and coordinated efforts of all of these agencies that comprehensive services can be provided to the migrant family. Listed below are the organizations with which we have an intimate working relationship. It behooves you to be aware of these organizations and their relationship to the Student Health Program in order to effectively provide services during the summer months that you will be working.

Migrant help and health agencies in Colorado:

- A. Colorado State Health Department
- B. Colorado Migrant Council
- C. Department of Education, Title I Migrant Schools
- D. University of Colorado Medical Center and Colorado General Hospital
- E. Migrant and Rural Coalition
- F. Migrant Ministry
- G. United Farm Workers Union
- H. Colorado Rural Legal Services

Finally, it should be mentioned that each of the rural communities in which the student health teams work, offer a variety of resources which have to be tapped in order to provide comprehensive services for the migrant families. Some of these resources are more difficult to obtain than others in the local communities. It is important to remember, however, that resources available in the local communities may in fact be more important than resources available from the above listed state-wide agencies. These resources might include local consumer action groups, local medical and dental societies, local hospital, local church groups, local planning councils, etc. Each of the student teams has mapped these local resources in the specific communities in which they have worked in order to facilitate the tapping of local resources. This past mapping will be made available to the teams as they are assigned to specific areas, but will require updating and expansion by each of the teams for the 1974 season.

A. Colorado State Health Department.
Executive Director - Dr. Ned Dreyfus

The State Health Department has a Migrant and Rural Poor Division which is under the direction of Mr. Silver Jaramillo. He is assisted by a Nursing Director, Virginia Lewis and Dental Director, Terri Swanson.

The State Health Department Migrant Division has had a program for the past 5 or 6 years operating in rural Colorado. The program is supported federally by the Division of Community Health Services in HEW and receives approximately \$250,000 a year. The program operates under 3 sub-divisions - nursing, medical and dental.

The nursing sub-division is under the direction of Ms. Virginia Lewis. She has 4 year-round nursing positions which are located in the major migrant impact areas of the state, including Northcentral and Northeast, the Arkansas Valley, the San Luis Valley and the Western Slope. These positions are funded through the HEW Migrant Health grant. In addition, during the summer months, through a contract with the Department of Education's Title I migrant schools, Ms. Lewis hires an additional 16 nurses to work out of the migrant schools. These schools are for children mostly from the ages of 6 to 18, however, some of the schools this summer will also have a Day Care component for infants. The nurses hired for the Title I schools work under the direction of the year-round HEW funded area nurses and in addition to providing school health, they also assist in delivering services to migrant families out of clinics that are established in the local communities. It should be emphasized that this component of the Program is perhaps the most important component of migrant health care in the state, since these nurses provide the interface for the migrant patient with professional health services.

The medical sub-division of the State Health Department's program provides reimbursement to local practitioners for ambulatory services which they provide. Authorization of these services is handled through the migrant nurses. It should be emphasized that these authorizations do not include hospitalization. Hospitalization must be arranged usually through Colorado General Hospital at the University of Colorado Medical Center and in rare instances in the local communities.

The dental sub-division of the State Health Department's program provides comprehensive dental screening for all the children in the Head Start centers and Title I migrant schools. This screening is carried out by the State Health Department with the assistance of the Student Health Program. Limited funds are available to provide care through the local dental practitioners.

In summary, Colorado State Health Department's migrant program is the major provider and coordinator for professional health services for migrants in the state. The Student Health Program triples their health manpower potential, thus the integration of the student health teams with the State Health Department's migrant nurses who provide local authorization of ambulatory services becomes obvious. In the integration of the State Health Department's nurses into the team is of extreme importance.

A list of the specific nurses and area nurse coordinators will be provided for the teams in each of the local areas.

B. Colorado Migrant Council.

The Colorado Migrant Council is a non-profit corporation, established in 1966 to improve general services for migrant farm worker families who come into Colorado. Early funding of the program was through the Office of Economic Opportunity, however, within the last year funding of the program has been transferred to the Department of Labor and at a reduced level. Consequently, the number of services which the Council has been able to provide has been reduced. The CMC is the major help agency for migrants in the state. It is almost entirely a Mexican/American organization which has been committed to improving the quality of life style of the migrant family. The organization strives to give the migrant needed emergency services, but perhaps more important, skills with which to improve his life style. CMC strives toward a decentralized organization which predominantly operates out of the 4 major migrant impact areas of the state - North Central and Northeast, the Arkansas Valley, the San Luis Valley and the Western Slope. Consumer boards from each of these areas offer input and direction to the organization.

There are about 3 major impact areas for which the Council strives. The first is the provision of emergency services. In this way, the council acts as a resource allocator to assist the migrant by providing monies for emergency food and transportation or, by assisting the migrant to receive public assistance in the local communities, channelling the migrant into health resources or legal resources, and perhaps most important to provide a friendly and receptive base in which the migrant can turn. The second major area in which the council strives for impact it to provide skills with which the migrant can improve his own health and economic status. The CMC has been involved in programs to settle out migrants and provide them with marketable skills. They have assisted settled out migrants in economic development, such as farm cooperatives, etc., and finally they offer GED courses to allow the migrant to complete his high school education. The third area of impact of the CMC is through their Head Start and Day Care program.

The CMC Head Start and Day Care program is an extremely important aspect of migrant health care in the state. Dr. H. P. Chase published results in the American Journal of Diseases of Childhood about the poor health status of the children in this program, and in an attempt to improve the health status, started the Student Health Program in 1970. The acting director of the Head Start and Day Care component of the CMC is Ms. Dorothy Passig from Lamar. Ms. Carol Brandel is the Nursing Director of the Head Start and Day Care component and will have approximately 8 nurses working out of these centers. The student health teams will assist these nurses in providing comprehensive screening examinations for the children, and these screenings will be reviewed by a team of pediatricians and child health associates from the University of Colorado Medical Center. Again, the importance of working cooperatively with the CMC Head Start and Day Care nurses cannot be over emphasized. Through these comprehensive screening exams with problem identification and appropriate follow-up, we hope to improve the health status of the migrant children.

C. Department of Education Title I Migrant Schools.

The Title I migrant schools provide a school setting for 10 weeks during the migrant season in rural Colorado communities. Children are enrolled through a large outreach worker component. The schools are attempting to implement a bilingual and bicultural curriculum. The Title I system initiated a computerized record system 3 years ago to record the childrens educational process. In addition, a health record has been attached to this computerized system and has recently been expanded in order to maintain an adequate health data base on the migrant children. This year for the first time, all of the Colorado Migrant Council Head Start and Day Care children will also be included on the computerized educational and health record form. Just as with the Head Start and Day Care children, the student health teams will also perform comprehensive screening examinations on all of the Title I school children. This will be done in a cooperative effort with the Title I migrant nurses who work under the direction of the Colorado State Health Department.

In addition to the screening and follow-up of the migrant children, we hope to initiate health education programs which will involve both the children and their families concerning such important topics as nutrition, dental hygiene, prevention of communicable diseases, etc. Two graduate community health educators and 4 graduate nutritionists will work closely with the student health teams and the Title I migrant school administration in initiating and carrying out these programs.

In summary, it can be seen that a major portion of the Student Health Program's activities center themselves in the migrant schools Head Start and Day Care centers. Activities generated out of the schools greatly influence the relationships that we are able to establish with the migrant families and to that extent affect the impact that we have on the migrant population.

D. University of Colorado Medical Center.

The Student Health Program for migrant farm workers and rural poor is based out of the University of Colorado Medical Center (UCMC), and in that sense serves as a home base for advise, consultation and referral. Because there are almost no funds available for hospitalization (federal, state or local), Colorado General Hospital and its sub-specialty clinics in the Out-Patient Department serve as an important backup for hospitalization and sub-specialty referrals.

The Student Health Program is based out of the Departments of Preventive, Division of Health Administration and the Department of Pediatrics. The medical directors are Dr. Stephen Barnett and Dr. Peter Chase. The business manager for the Program is Ms. Pat Cummins, who works out of Dr. Barnett's office. This is the fifth year of existence for the Student Health Program which has strived to achieve 4 objectives; first and perhaps most important has been to increase the number and quality of health services to migrants in rural areas of health manpower scarcity. In 1973, a little over 40 students saw close to 16,000 patients, working out of 12 rural agricultural communities. Utilizing professional health skills of students in screening and triage, health care services have become more accessible and available to migrant farm worker families in Colorado. Second, the Program offers an extended rural community health experience exposing health science students to the systems and non-systems, its complications, intricacies and potentials of rural health care in Colorado communities. All too often health science students are not prepared for the realities of a practice in the community setting. The Student Health Program provides students with skills to implement their professional training into the community. Third, the Program offers students an interdisciplinary team experience with which to approach the problems of delivering health care to migrants and rural poor. The pros and cons of this approach are not well documented, though there are many theoretical advantages. Thus, students participating in the Program are contributing to an experiment to better define the advantages and disadvantages of the interdisciplinary team approach to health care. Fourth, finally, we hope that through such an experience students are "turned on" to the exciting challenges and potentials of working in a rural community health setting.

Since the UCMC is the base for the Student Health Program, several orientation meetings will be held here and in addition, bi-monthly seminars are held following the orientation sessions. The purpose of these orientation sessions is to provide the students with specific skills with which to tackle the problems they face in rural communities and to also provide a forum for group problem solving and progress made in the individual communities. It should be emphasized that the Program Director, Dr. Barnett, encourages the liberal use of telephone consultations with all of the students and regardless of whatever problem area may arise.

Colorado General Hospital and its sub-specialty clinics are a major and integral part of the migrant referral system in Colorado. Referrals are made after all local community resources are exhausted, but often the local communities do not have available resources. All referrals to

CGH are handled through the Colorado State Health Department migrant nurse referral form. All of these referral forms should be sent through Francis Lavato, who is the Migrant Advocate at CGH. Ms. Lavato arranges for admissions and schedules sub-specialty clinic visits, assists in receiving the migrant patients at CGH and tries to insure adequate response in follow-up back in the rural community. Working with Ms. Lavato is crucial to facilitating care for the migrant family that comes to CGH. Dr. Barnett, the Program Director, may be helpful in insuring appropriate referral and consultation. Transportantion mechanisms to CGH and Denver are complicated, especially with the energy crisis. Transportation responsibilities will be shared by all migrant help agencies, including the Student Health Program and a specific schedule will be worked out in each of the rural areas.

E. Migrant and Rural Coalition of Colorado.

The Migrant Coalition was formed approximately 3 years ago with the purpose of better coordinating all of the resources of the state to improving the status of migrant farm worker families in Colorado. Within the last year, these goals and objectives have also been expanded to the rural poor in Colorado which largely consists of Mexican/American families involved in seasonal agricultural work. The Coalition itself is not involved in the provision of services, but rather serves as a consortium through which migrant help related agencies can better plan and organize their resources to promote cooperative efforts and avoid duplication of scarce resources. The organization that is in the process of becoming incorporated in order to obtain a non-profit tax exempt status must be able to obtain funds to establish an administrative staff.

Attached is the 1973 membership list of the Coalition which demonstrates the broad based participation in the state. One can see from this long list, there are a host of various resources which can be tapped for migrants. To maximize all of these resources that are available, is often a nightmare. Consortia by definition are a loose arrangement between organizations and agencies which have some common goals, but the individuals of the organizations and agencies remain almost completely independent. In an attempt to better define the responsibilities and obligations of the health related participants in the Coalition, the Co-chairmen of the Coalition's Health Committee, Dr. Stephen Barnett and Mr. John Gillespie, initiated in 1973, work oriented task forces around 3 topics: record systems, transportation systems and manpower utilization systems. The purpose of these task forces were to establish written memoranda of understanding between the health related agencies in order to improve the planning process for the 1974 migrant season. Hopefully the result of these work oriented task forces will be better planning, cooperation and coordination amongst the health related migrant help agencies of the state.

Finally, it should be mentioned that the Coalition serves to promote many other important areas for the migrants in the state through legislation, improved housing, better working conditions and educational opportunities.

F. Migrant Ministry.

The Migrant Ministry was perhaps the first migrant help agency established in the state over a decade ago. It is currently under the direction of the Rev. Jim Selmser. The Ministry attempted to establish a host of resources in the rural agricultural communities of Colorado through voluntary agencies and local church groups. During the summer, Rev. Selmser has students in the ministry work in migrant impact areas of the state. Because of limited financial resources for the past few summers, this has been limited to only 3 or 4 students. These students assist in identifying emergency food and transportation resources as well as spiritual support for the migrant families. In addition, they try to organize the local voluntary resources in the community that can be made available. These students are often important facilitators and when feasible should be included in the student health teams activities. A listing of these students and their working locations will be available this summer.

G. United Farm Workers Union.

The United Farm Workers Union was established in the early 1960's by Caesar Chavery in California. The farm laborers have never come under the protective legislation established in this country for other working groups. Thus, it has been extremely difficult for Mr. Chavery to establish union recognition for agricultural workers. The Union has never been able to establish an adequate financial base with which to deal with the large grower associations and agricultural cooperatives, nor to protect itself and its membership from invasion by the large, well-healed and established unions. Thus, the history of UFW has been a stormy one and usually has had to rely on the sympathys of the American public to achieve its ends in improving the life and working conditions of the farm worker and his family.

UFW activities began in Colorado in the summer of 1970. There were 2 arms established. One was the boycott unit established in Denver and now under the direction of Richardo Longoria. The other arm of the Union was established in the San Luis Valley by Magdeleno Avida. The Student Health Program has primarily worked with the organizing arm of the Union in the state, because it is this section of the Union that relates directly to the field workers. Because of very few resources available to the Union here in Colorado, their activity has primarily been limited to the San Luis Valley where in 1970 and again in 1973, lettuce strikes were called. The Student Health Program has avoided becoming embroiled in strike activities, in order that they can more effectively make available local health resources to those farm workers in need. Thus, in the San Luis Valley, the Union serves as an important facilitator of the farm workers to the student health teams, and in turn, the student health teams serve as a facilitator for the farm workers into the local and statewide professional health services. The student teams, in addition to providing screening and triage to the farm workers, often have assisted in teaching farm workers self help skills, first aid and emergency measures.

H. Colorado Rural Legal Services.

The Colorado Rural Legal Services was established in the late '60's by Johnathan B. Chase, a law professor from the University of Colorado. The program was established under the Office of Economic Opportunity and because of Mr. Chase's deep concern about the plight of the migrant farm worker in Colorado, much of the focus of CRLS was to improve those conditions. It is important to understand that there are many operating constraints to CRLS as a result of its federal funding. Their functions are limited to civil law and do not include any criminal proceedings and, in addition, there has been a major attempt by the Federal Administration to dismantle legal services programs around the country. When the Student Health Program first started in 1970, law students working out of CRLS were teamed with the medical students working in the rural communities. The rural health providers (physicians, public health nurses, hospital administrators) were extremely anxious about the presence of the law students and this significantly impeded the services which the medical students could generate. Thus, the health students the following summer were teamed with the local health providers rather than the law students, although they continued to have a close working relationship. As a result of this organizational change, the health students have been much more successful in generating local health resources for the farm worker families. In 1973, the severe financial and administrative cuts to CRLS resulted in discontinuing their legal student program and much of their migrant farm worker activity. The new director of CRLS, Mr. Art Lucero has been successful in re-establishing the law student program and plans to have approximately 6 students working on migrant farm worker problems in the 1974 season.

There are many areas in which CRLS and the Student Health Program overlap and it is in these overlapping areas that we hope that health students from the Program can work closely with the CRLS legal students. These areas are concerned with occupational safety and health standards and will be of great importance in the 1974 migrant season. Establishing federal occupational standards for agricultural workers has been slow to evolve here in America. At present, much of this responsibility has been recently been delegated to a newly established division in the State Department of Health (Colorado Occupational Safety and Health or COSH). Major areas of importance include field sanitation, housing sanitation, adequate accident prevention and pesticide control. Just how these standards will evolve and be enforced in Colorado remains to be seen, but the 1974 migrant season may well lay the foundation for the establishment of these standards.

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